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Correspondence

Erratum

THE EDITOR:

The error is probably mine but I'd like to make a rrection regarding the article on page 494 of the ay-June, 1959 issue of the HAWAII MEDICAL JOURNAL. The portion of the article beginning in column 1, ragraph number 4, starting "a further facet of the rk" until the end of complete paragraph number 2, umn 2 on page 494, beginning "finally, certainly sue culture" and ending "will stand us in good stead" ould all be placed at the end of the article following paragraph ending "response to various agents." In is way the context will be clearer.

I hope that this correction can be used if you see fit.

W. HAROLD CIVIN, M.D.
Director of Laboratories
The Queen's Hospital

The error was ours. Sorry!—ED.

omment from the National Foundation

O THE EDITOR:

I have had an opportunity to read the editorial con- rning The National Foundation which you have pre- ared for the September issue of the HAWAII MEDICAL OURNAL. Carolyn Patterson, our State Representative r Hawaii, thought that I might wish to comment and think it best if I write you directly.

At no time have we maintained that polio is licked nd that we have accomplished our principal mission. I m sure you would agree that through The National oundation's programming, a means has become avail- ble to eradicate epidemics of paralytic poliomyelitis. he problems of getting people vaccinated have not been eferred to in your editorial, nor have you mentioned ne efforts of The National Foundation to assist the nedical profession in achieving this goal.

It is difficult to reply to such sweeping criticisms of he National Foundation which apparently reflect your ersonal opinion. The more fundamental issues which ave influenced The National Foundation's planning for he future are not discussed. For example, there is no eference to the nature and significance of past and cur- ent research programs of The National Foundation and he desirability of their continuation. Furthermore, you ave not mentioned the question of the role of voluntary ealth associations in support of research as compared o government.

You label our professional education and research rograms as "generous," but make no comparisons or stablish any criteria for such a judgment.

In your last paragraph, you say "We cannot approve f it and we will not support it." Are you speaking for he editorial staff of the JOURNAL, or your State Medical Association? If you are communicating an opinion of an fficial medical group, what investigations led to its con- lusions and by what democratic process were these ecommendations made?

There is certainly no reason why you should not pre- ent just and thoughtful criticism of The National oundation. I would certainly think, however, that it would be based on an objective study of the many issues

(Continued on page 112)



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Rosie Chang, R.N., M.Litt., *Edito*

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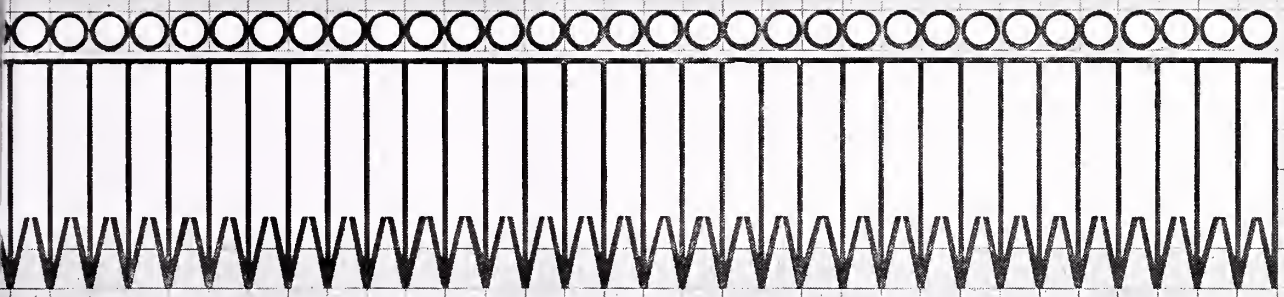
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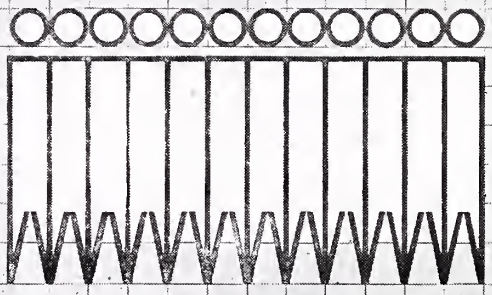
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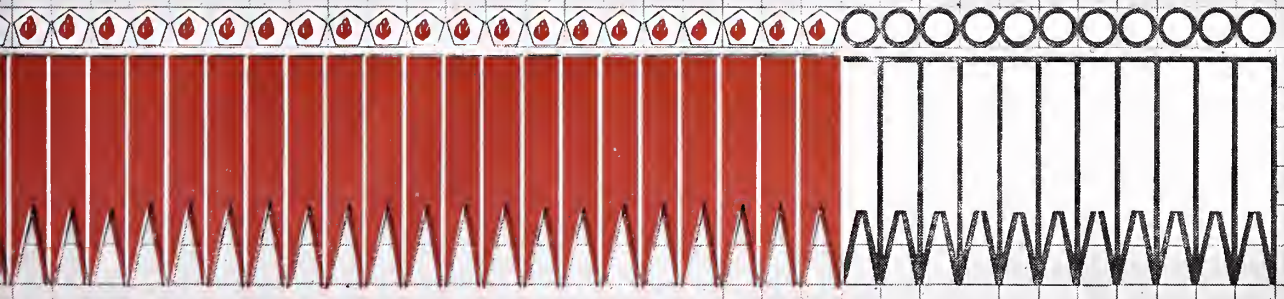
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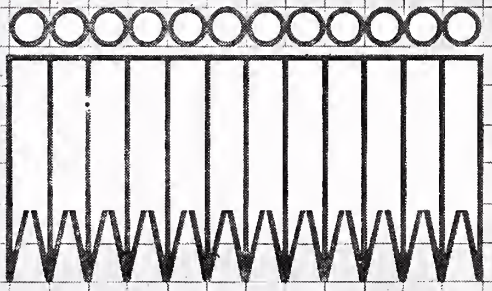
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1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
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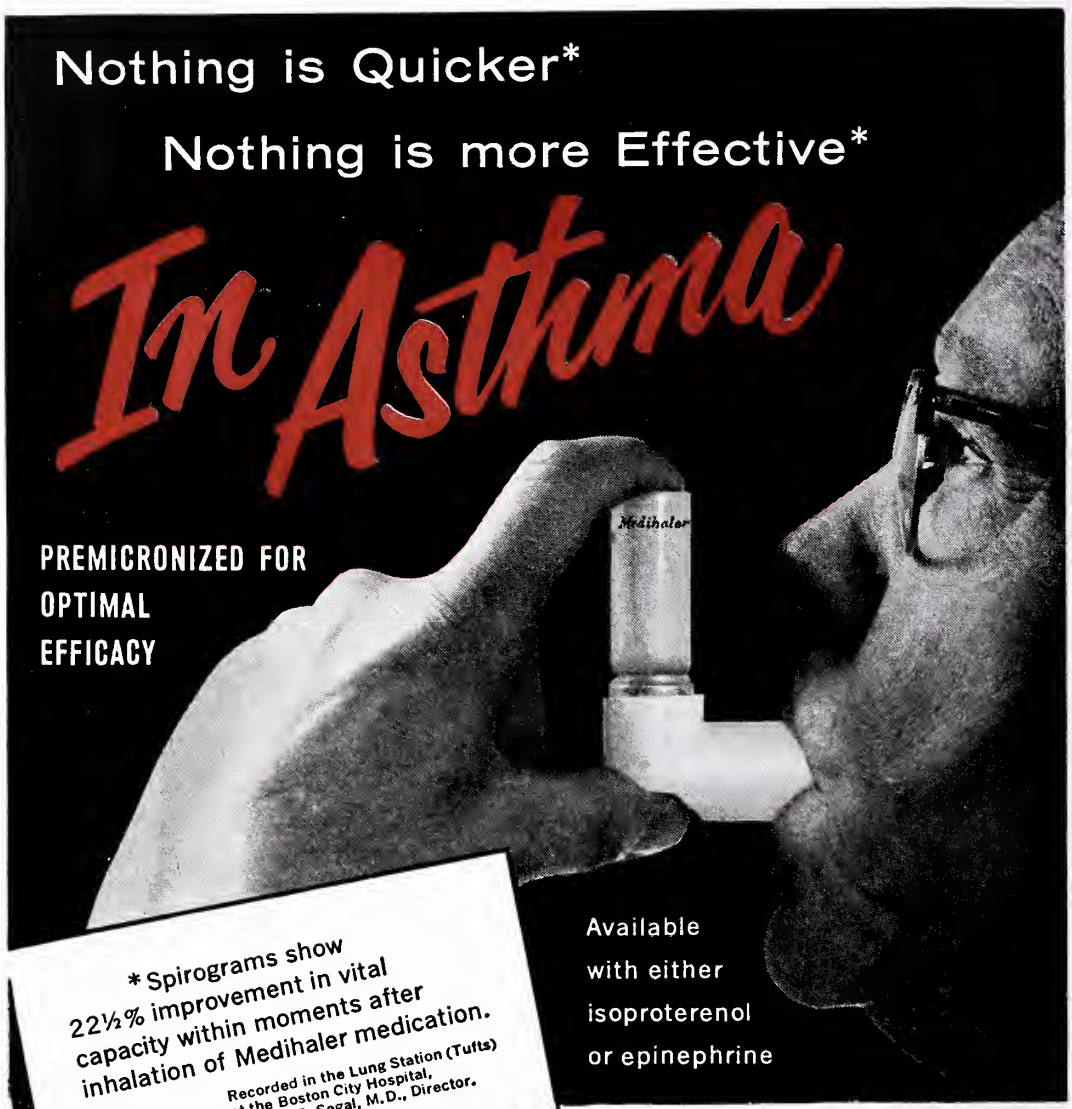
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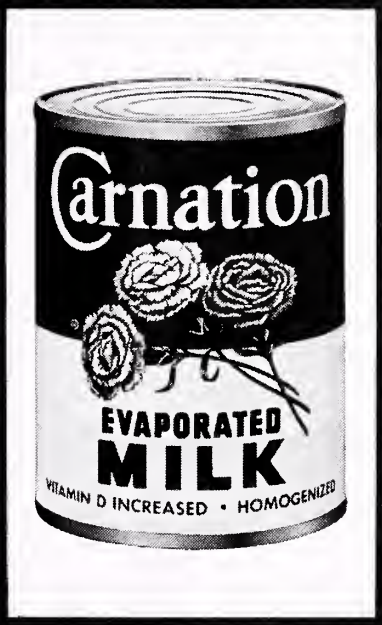
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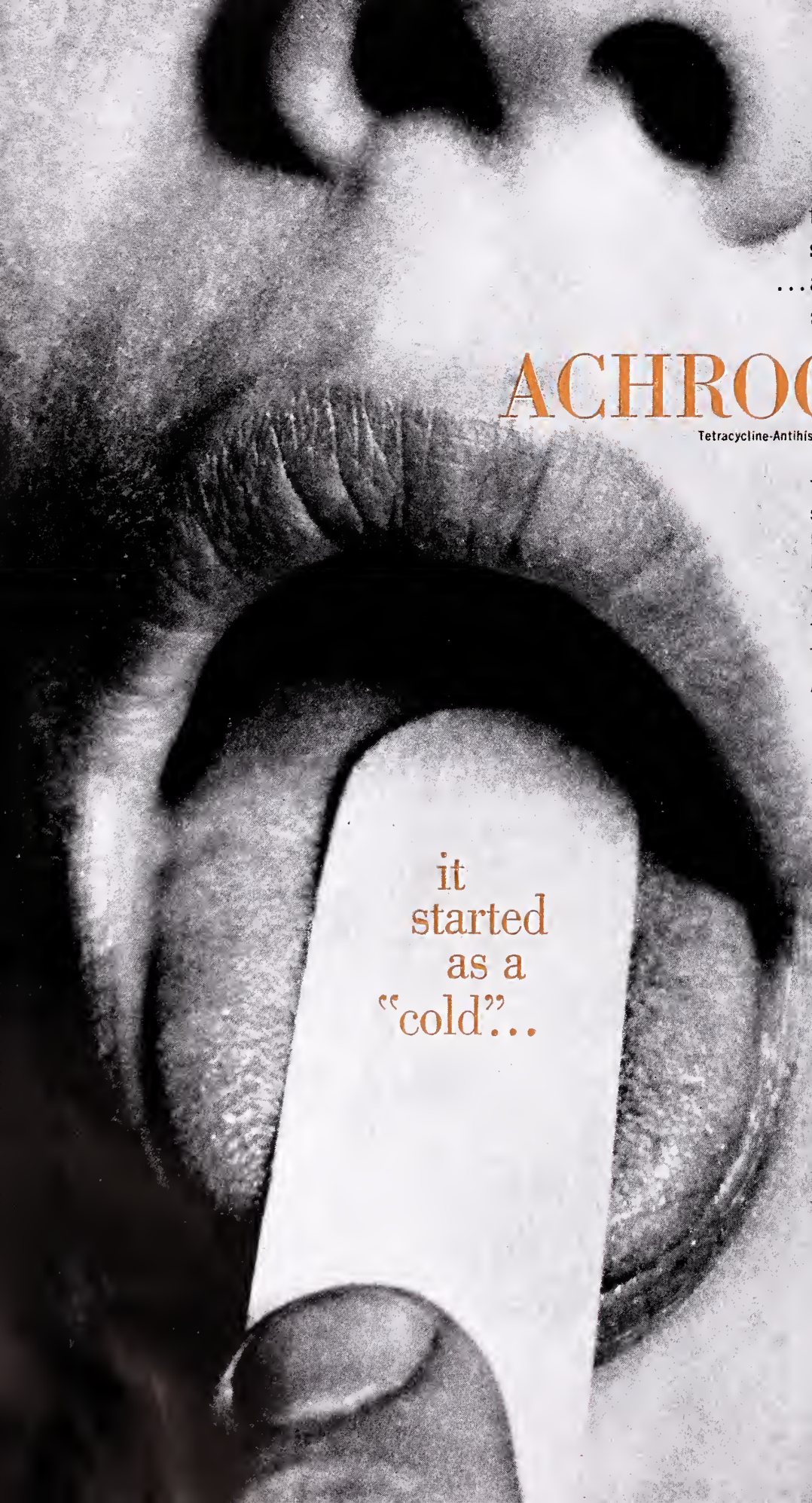


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Galeota, W. R., and Moranville., B. A.: Student Medicine (in press)

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1. Based on estimate by Van Vol
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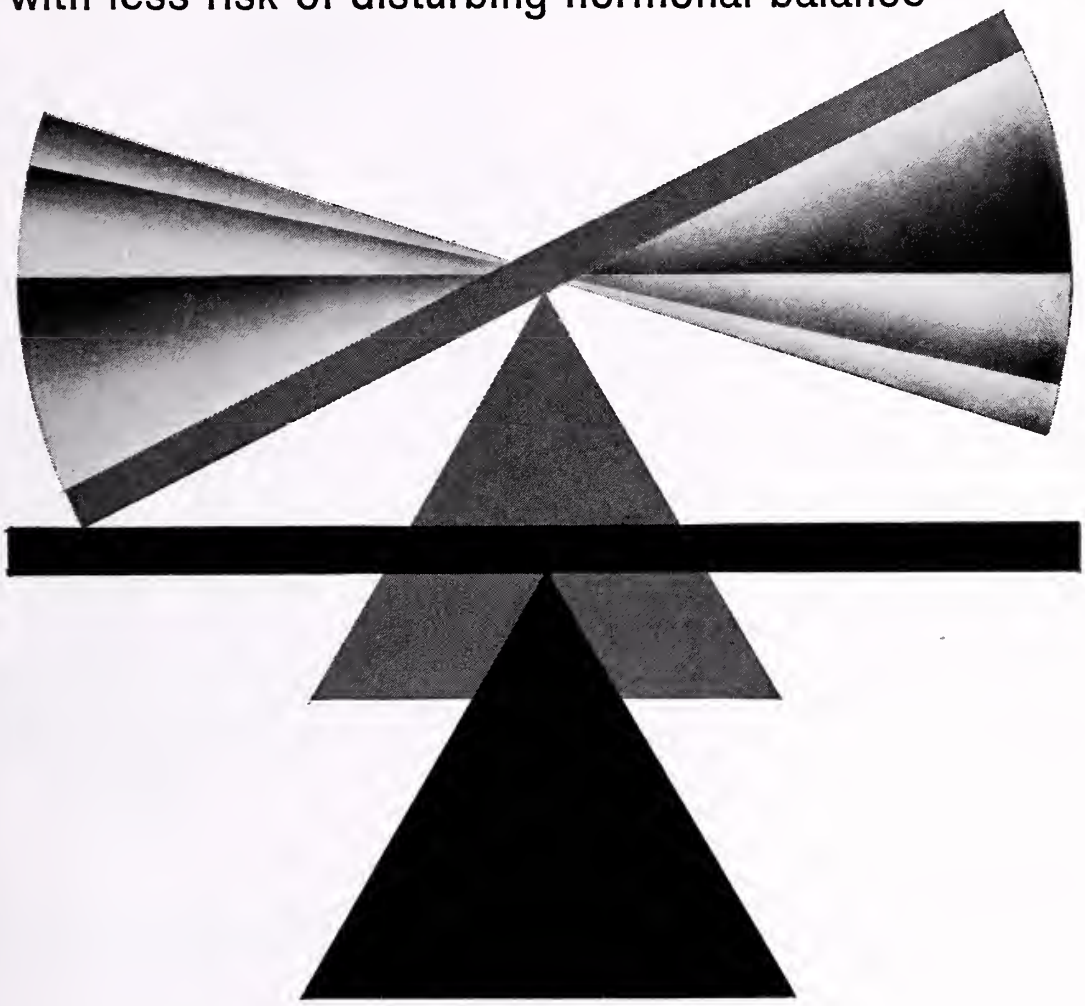
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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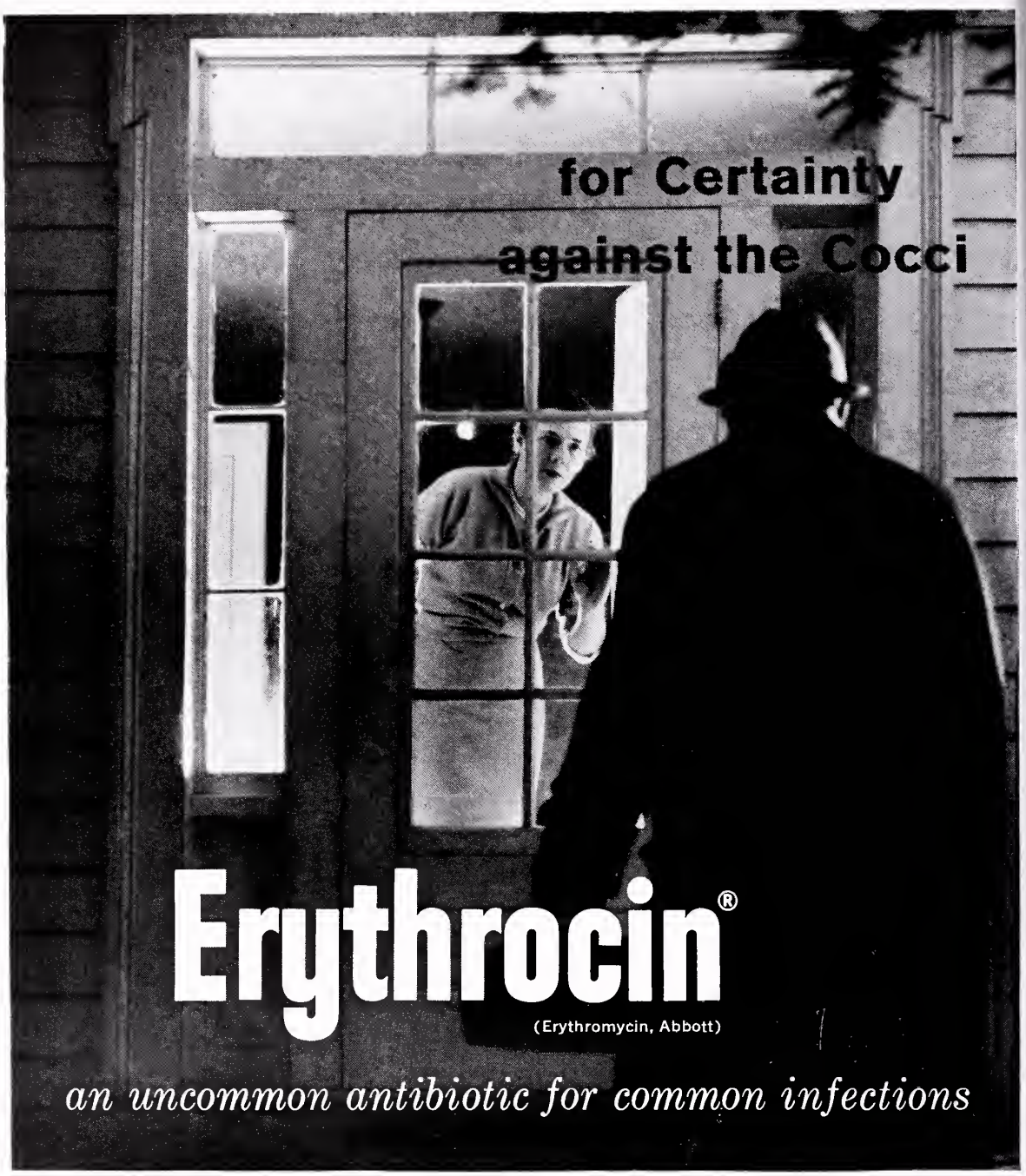


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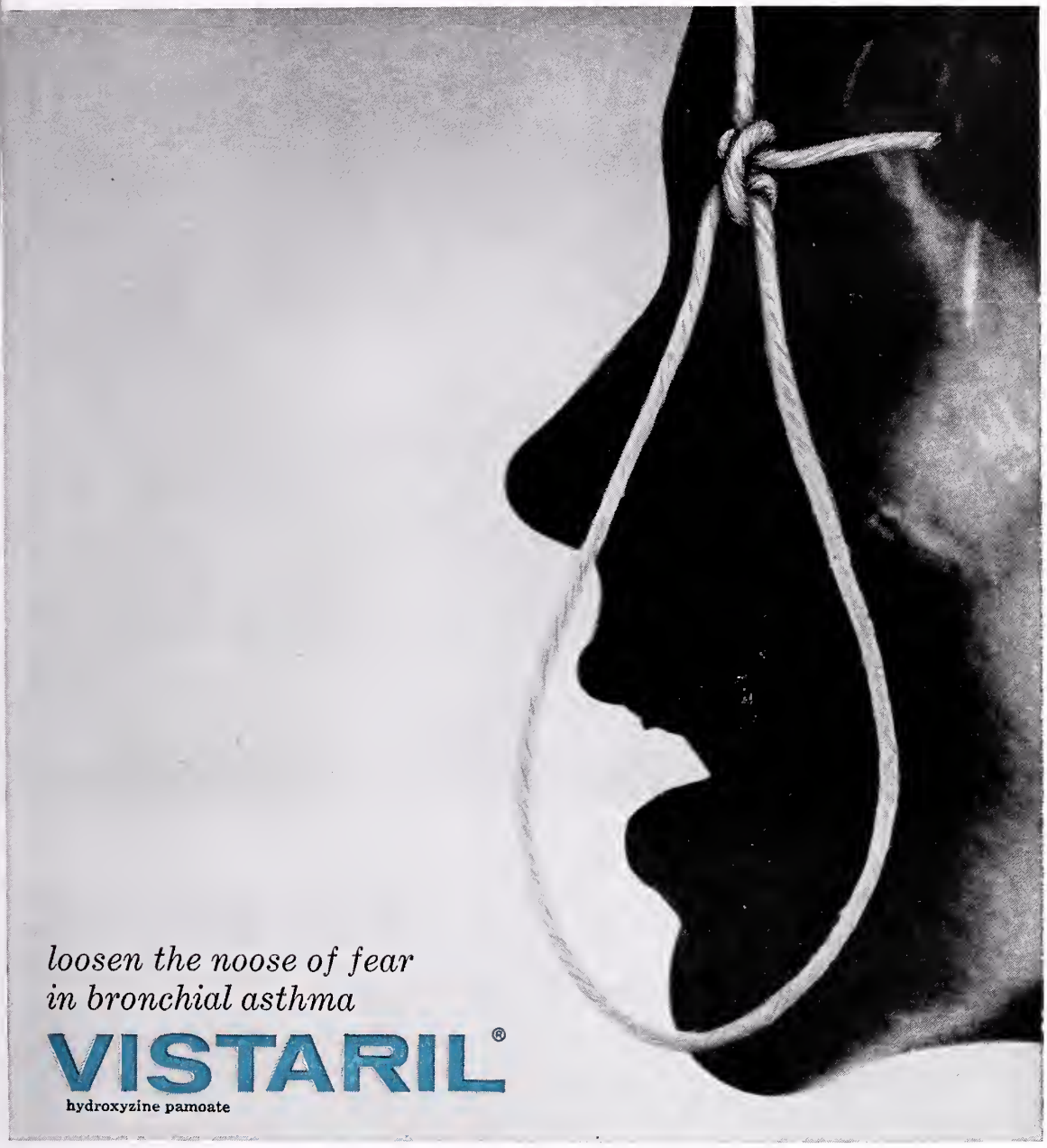


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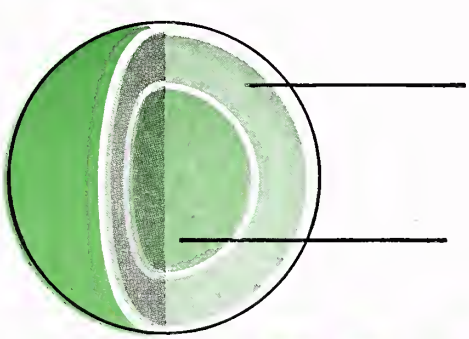
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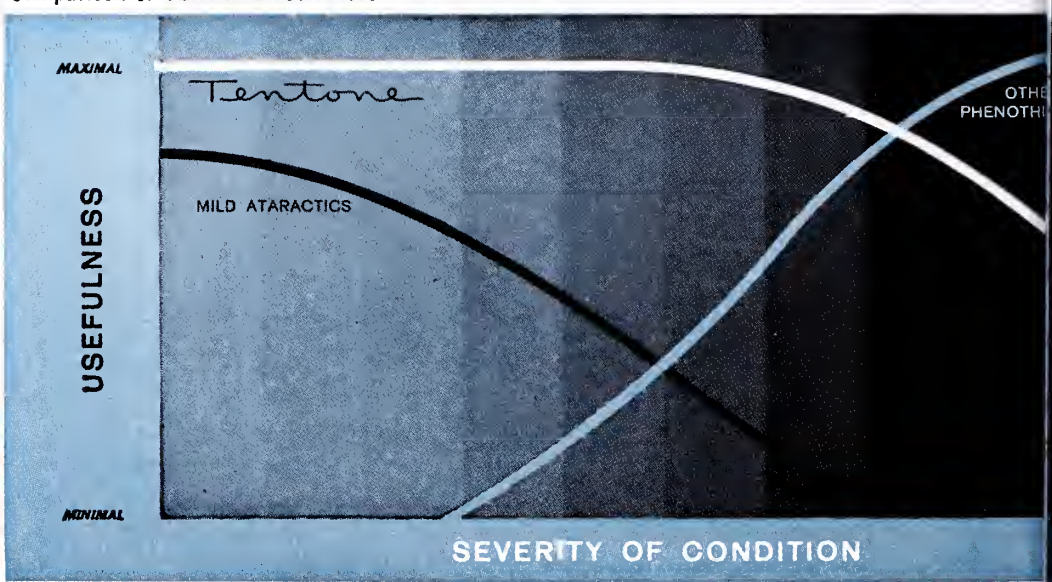
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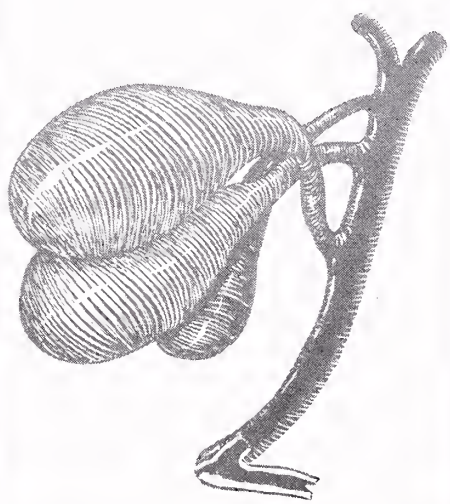


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Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



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(1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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Bibliography: (1) Riehl, G.: Griseofulvin: An Orally Active Antibiotic, presented at Austrian Dermat. Soc. Meet., Vienna, Nov. 27, 1958. (2) Williams, D. I.; Marten, R. H., and Sarkany, I.: Lancet 2:1212, 1958. (3) Blank, H., and Roth, F. J., Jr.: A.M.A. Arch. Dermat. 79:259, 1959. (4) Goldfarb, N., and Rosenthal, S. A.: Current M. Digest 26:67, 1959. (5) Reiss, F.: Medical Circle Bulletin 6:9, 1959. (6) Robinson, H. M., Jr.; Robinson, R. C. V.; Bereston, E. S.; Manchey, L. L., and Bell, F. K.: Griseofulvin, Clinical and Experimental Studies, presented at Am. Dermat. Assoc. Meet., Atlantic City, N. J., June 3, 1959.

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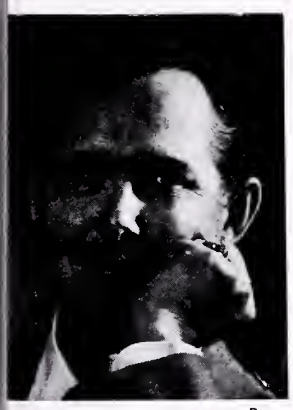
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Though Hawaii has the mosquito vectors of virus encephalitis, we are taking care not to import infected bird reservoirs of the disease.

Arthropod-Borne Virus Encephalitis Potentials in Hawaii

WALTER B. QUISENBERRY, M.D., M.P.H.,* AND
GORDON D. WALLACE, D.V.M.,† Honolulu

ARTHROPOD-BORNE animal viruses are able to infect certain vertebrates—mammals and birds—and to multiply in the body of arthropods—mosquitoes, ticks, etc. Examples of these viruses are those which cause St. Louis, Eastern and Western equine, Russian spring-summer, and Japanese B encephalitis. It is stated that "except under unusual circumstances these viruses are not capable of spreading from vertebrate to vertebrate without the agency of an arthropod. The arthropod is the vector and becomes infected generally by ingesting blood from a vertebrate host at the time when the virus circulates in the latter. After a period of days designated as extrinsic incubation, the vector by biting can transmit the disease to a new susceptible host. Infection of the vector can also occur by transovarian transmission of the virus in the case of ticks. So far as is known, the virus does not cause any apparent ill-effects on the vector, nor are any lesions detectable in the tissues of the arthropod."[1]



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How Long Have Arthropod-Borne Virus Diseases Been Known?

In the past 30 years nearly 50 distinct viruses have been found[1] to be arthropod-borne, and through research new viruses are being added to this group every year. They have been found on every continent, yet geographic information on their distribution is quite incomplete. Historically it is worthwhile to note that yellow fever was the first disease in which dependence on an arthropod vector for the transmission of the virus to man was proved.

Hawaii In A Hazardous Position

Hawaii might be considered to be in a hazardous position in regard to the introduction of arthropod-borne encephalitis, especially from the Orient. Our nearness to the Orient makes us a more potentially hazardous area for the introduction of Japanese B encephalitis than any other state in the United States. Rapid air travel and increasing numbers of airplanes and passengers arriving have multiplied the danger of hosts or vectors of disease being brought in. An isolated outbreak of Japanese B encephalitis on Guam in

* Director, Division of Preventive Medicine, Territorial Health Department, Honolulu.
† Consultant, Comparative Medicine and Veterinary Public Health, Territorial Health Department, Honolulu, Hawaii; on loan from the Communicable Disease Center, Public Health Service, U. S. Department of Health, Education and Welfare, Atlanta, Georgia.

[1] Rivers, T. M., and Horsfall, F. L., Jr.: Viral and rickettsial infections of man, 3rd ed., Lippincott, Philadelphia & Montreal, 1959, pp. 269-283.

1948 showed that transoceanic transportation of the disease can occur.[2]

Mammals and Birds Hosts in the Orient

Arthropod-borne encephalitis has been found in both birds and mammals in the Orient. Hammon *et al.*[3] reported in 1957 on a serologic survey of Japanese B encephalitis virus infection in birds in Japan. As stated by the authors, Japanese and American investigators have believed that Japanese B encephalitis infection is transmitted by mosquitoes principally from large mammals and not from birds. These investigators designed a study to determine the extent of wild-bird infection in Japan. Sera were tested from 1,705 birds of 154 species. A total of 19.8 per cent of the birds tested, representing more than 34 species, was positive for Japanese B encephalitis antibodies. The authors "concluded that birds in large numbers are infected with Japanese B encephalitis viruses and might serve as an important source of mosquito infection." However, they felt that further studies should be done to confirm their conclusions. Some serologic examinations have been done here in Hawaii on game birds imported from Japan to determine whether their blood contained antibodies against Japanese B encephalitis virus. This will be discussed later in this report.

Pigs, horses, and bats have been considered hosts of arthropod-borne encephalitis. There seems to be no general agreement on whether man can be a host of the disease. However, most workers feel that he cannot. It is believed that this is due to the low level of viremia and the short period of time that the virus circulates in the blood of man.

Since mammals (other than humans) which might be hosts of encephalitis will rarely be imported to Hawaii from the Orient or from other areas, no further consideration will be given to this group at this time.

Do We Have Vectors in Hawaii?

Hawaii has mosquito vectors which are considered capable of carrying encephalitis virus. Of the three species of mosquitoes in Hawaii, two are potential vectors. Aedes albopictus has been shown to be capable of being a vector of Eastern and Western encephalitis. Culex quinquefasciatus has been known to transmit Urban St. Louis encephalitis.[4] Laboratory studies in Japan and the United States have shown that Aedes albopictus and Culex quinquefasciatus can be vectors of Japanese B encephalitis. The latter is a suspected vector in Okinawa.[2] However, so far as can be determined, it has never been proved to be a natural vector of this disease. In Japan the principal vector of Japanese B encephalitis is Culex tritaeniorhynchus. This species is not found in Hawaii, but specimens have been brought in on airplanes. The only ones found thus far have been dead. However, some may have escaped. Control measures in effect for many years are being expanded as much as possible to meet the needs created by increased rates of transportation.

Potential Hosts Brought Into Hawaii Are Being Checked

Song birds and pheasants have been imported into Hawaii from the Orient in the past. A shipment of bamboo pheasants from Japan was received by the Department of Agriculture and Forestry early in February 1959. There were approximately 60 birds both young and full grown. They originated from Miyakejima, near Tokyo. Japanese B encephalitis is considered endemic on this island. The imported birds had been grown in the wild and were trapped with nets.

Blood specimens were collected from 40 of the pheasants on February 9, 1959, and the sera were subsequently tested for the presence of Japanese B encephalitis hemagglutination-inhibiting antibodies with negative results. This lack of antibody may be explained in part by the seasonal occurrence of Japanese B virus activity in Japan. The seasons of highest activity are late spring, summer, and early fall.

About the first of July, 1959, Mr. Paul Breese, Director of the Honolulu Zoo, received a shipment of 80 young cattle egrets from the east coast of Florida. These birds are to be used for insect control and are being distributed on Hawaii, Kauai, and Oahu. Forty-eight of these have had sera taken for encephalitis virus antibody determinations, and they have been tested for Eastern equine encephalitis antibody by the hemagglutination inhibition test and found negative. Florida is known to be an endemic area for Eastern equine encephalitis.

Human Role in the Epidemiology of Arthropod-Borne Encephalitis

Human infection generally is only incidental to the perpetuation of anthropod-borne encephalitis infection. The most important epidemiologic procedure is to identify the biological circumstances on which the parasite depends for survival; the pattern of disease in human populations thus takes

[2] Bayliss, M. W.: Personal communication.

[3] Hammon, W. McD., Sather, G. E., and McClure, H. E.: Serologic survey of Japanese B encephalitis virus infection in birds in Japan, Am. J. Hyg. 67:118-133 (Jan.) 1958.

[4] Hess, A. D., and Holden, P.: The natural history of the arthropod-borne encephalitides in the United States, Ann. New York Acad. Sci. 70:294-311 (June 3) 1958.

a position of secondary epidemiologic importance. The viruses may be recovered from arthropods before any accompanying infection or disease is identified in vertebrate hosts. Thus the usual epidemiologic approach is reversed.

It is usually stated that[1] "Transmission of virus from one vertebrate host to another depends on one or more arthropod species and will occur rarely, if at all, by other means such as contact between hosts. This dependence on arthropods is proved or strongly implied by fairly constant association of the vector with the clinically or subclinically infected host."

It is often very difficult or impossible to determine whether all the necessary relationships exist between the host, the viral agent, and the arthropod. This information is incomplete for most viral agents considered arthropod-borne.

Biological transmission of arthropod-borne encephalitis consists of the following steps:[1]

1. A critical minimum amount of virus is necessary to establish infection in the arthropod vector.
2. During extrinsic incubation in the vector, the period between ingestion and transmission by bite, the virus multiplies and reaches the salivary glands of the arthropod.
3. The vector transfers virus to the vertebrate when it feeds on it.

The infection chain seems to be[1] vertebrate host →vector→vertebrate host→vector. It should be pointed out that the vector often bites a human being or a nonhost bird or animal along the way, and the human being or the nonhost bird or animal would be considered a dead end so far as the virus is concerned.

Because human beings are considered blind alleys in most arthropod-borne encephalitis, they are of little concern as hosts for continued survival of the virus here in Hawaii. This would mean that even though a person in the incubation period of the disease should be brought in by plane, and we had the mosquitoes present which could be vectors of the disease, there would be no potential hazard of the disease spreading to other people.

It should be pointed out that relatively few people who are infected by arthropod-borne viruses will show clinical signs of disease, even though they may develop antibodies. Baseline serologic studies are being conducted here in an effort to obtain information on what viruses our people have had experience with.

Summary and Conclusions

1. Hawaii is in a potentially hazardous position for importation of infected animal hosts of arthropod-borne virus encephalitis, particularly Japanese B encephalitis.

Available information indicates that although an epidemic is possible, ecological conditions are unfavorable to the establishment of an endemic situation in Hawaii.

2. Controls on importation or possible importation of infected mosquito vectors are being expanded as much as possible. Potential breeding of resident mosquitoes which might be vectors of encephalitis is also being controlled. The legislature appropriated additional funds for this activity during the last session.

3. Baseline antibody studies aimed at obtaining information on what viruses our people have had experience with are being carried on.

4. Game birds imported from encephalitis-endemic areas, which may be hosts of encephalitis, are being checked for virus and antibodies.

5. It may be found necessary to restrict the importation of game birds during the seasons of high incidence of encephalitis in the Orient, particularly Japan. Or it may be found more desirable to restrict imports to autumn, winter, or early spring (seasons of low encephalitis incidence) or possibly restrict them to particular islands. The northernmost island of Japan, Hokkaido, is normally free of Japanese B encephalitis throughout the year, and imports from that island would not need restriction.

Summario in Interlingua

Encephalitis a virus portate per arthropodos es transmittite per certe mosquitos ab un animal hospite (principalmente aves) al altere, e a vices accidentalmente e intermediarimente a humanos. Subjectos human non functiona como fonte de infection pro animales o altere humanos. Aves importate (in Hawai) ab Japon es scrutinate pro virus o anticorpore, sed usque nunc nulle tal ha essite trovate. Si virus o anticorpore es trovate in ille aves, il va possibilemente devenir necessari restringer lor importation a certe periodos del anno o a invios ab areas non-endemic. Le risco que encephalitis virusal pote devenir endemic in Hawai es serie e real sed extrememente basse.

Acknowledgment

The authors wish to express sincere gratitude to Robert E. Kissling, D.V.M., M.S., Virologist, Virus Laboratory, Bureau of Laboratories, Territorial Health Department, Honolulu, Hawaii, on loan from the Communicable Disease Center, Public Health Service, U. S. Department of Health, Education and Welfare, Montgomery, Alabama, and to Mr. Patrick Y. Nakagawa, M.S., Chief, Bureau of Mosquito Control, Division of Sanitation, Territorial Health Department, Honolulu, Hawaii, for their assistance in making this report possible.

A common seaweed seems to have learned to burn swimmers who don't bathe promptly after swimming

Dermatitis Escharotica Caused by a Marine Alga

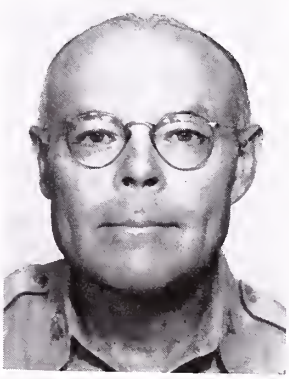
COLONEL FRANKLIN H. GRAUER, MC, US Army, Honolulu

MARINE ANIMALS[1] have long been known to produce acute dermatitis on contact with the human skin. The eruption described herewith, however, is the first (to my knowledge) to be due to contact with a marine plant, a seaweed. This dermatitis has been shown experimentally, by employing the patch (skin) test, to be produced by contact with a marine blue-green alga, which has tentatively been identified as Lyngbya majuscula Gomont[2] (Fig. 1).

During July and August, 1958, an acute dermatitis, previously not reported in Hawaii, occurred in swimmers frequenting windward beaches on the island of Oahu. During this period more than 125 cases received treatment for this disorder and hundreds of mild, unreported cases were suspected. Cases occurred at beaches from Laie and Kaaawa to Lanikai and possibly Waimanalo, with no instances of occurrence in Kaneohe Bay (Fig. 2). In the experience of local dermatologists, health authorities and general physicians,[3] this form of dermatitis is brand new—unique in the Islands. Similar cases have again been encountered on the windward beaches during the latter part of June and during July, 1959, with the most severe cases being reported at Laie.

Rash Resembles Burn

The dermatitis classically follows the same characteristic pattern: swimming, often in water made turbid by suspended fragments of seaweed, for periods varying from a few minutes to an hour or more; continuing to wear the wet bathing garments for a similar period after leaving the ocean, before showering; gradual onset of itching and burning within a few minutes to a few hours afterward; visible dermatitis beginning with redness after perhaps three to eight hours, followed by blisters and deep desquamation, leaving a moist, bright red, tender and painful area on the scrotum, perineum, or perianal area (Fig. 3). The eruption affects the region of the body covered



COLONEL GRAUER

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[1] Crutchfield, E. D.: Dermatitis from Portuguese Man-of-War, Arch. Dermat. & Syph. 12:72, 1925.
Levin, O. L., and Behrman, H. T.: Coral dermatitis, Arch. Dermat. & Syph. 44:600, 1941.
De Oreo, G. A.: Dermatitis venenata resulting from contact with marine animals (hydroids), Arch. Dermat. & Syph. 54:637, 1946.
Arnold, H. L., Jr., and Bonnet, D. D.: Swimmers' itch: its first appearance in Hawaii, Proc. Hawaiian Acad. Sci. 25:4, 1950.
Chu, G. W. T. C.: First report of the presence of a dermatitis-producing marine larval schistosome in Hawaii, Sci. 115:151, 1952.
Chu, G. W. T. C., and Cutress, C. E.: Dermatitis due to contact with the hydroid, Syncoryne mirabilis (Aggassiz, 1862), HAWAII MED. J. 14:403, 1955.

[2] Grauer, F. H.: Clinical Investigations, in Arnold, H. L., Jr.; Grauer, F. H.; and Chu, G. W. T. C.: Sea Weed Dermatitis Apparently Caused by a Marine Alga—Preliminary Report (Nov. 25, 1958), Proc. Hawaiian Acad. Sci. In press.

[3] Arnold, H. L., Jr.: Personal communication.



FIG. 1.—Olive drab in color, a hair-like mass, fragments of which act as the offending agent.

by the swimming trunks and in the case of women occasionally appears in the breast area, particularly those wearing a closely fitting brassiere.

One patient complained that the eruption produced a constant discomfort as if following a match burn. He reported that his small niece developed an "intensely burning, irritating, turbid, doughnut-shaped, perianal blister which was one-half inch in diameter." Local physicians have described cases as varying from a mild skin rash to one resembling a severe contact dermatitis—"swollen, raw and itchy, in some instances disabled its victims for several days." Other cases have been described as having a "terrific dermatitis" and the patients looked as if they had "been singed with a blow torch."

The treatment is that of a superficial chemical or thermal burn. Healing under wet compresses and bland ointments occurs rapidly and is complete in all cases within a week or so. Topical steroid applications are rarely necessary and parenteral steroids are practically never indicated.

Suggestions as to why this particular type of seaweed has caused trouble are that it may possibly represent vegetation from the ocean depth which has been uprooted in large quantities and brought in from the open sea by occasional tide changes, following storms and seismic disturbances and driven on windward Oahu beaches by strong trade-winds. The beaches where this alga has caused trouble are all situated on the windward side of



FIG. 2.—Map of Oahu showing locations of the windward beaches.

the island and have direct access to the open sea. Further evidence suggesting that the alga may come from the open sea is the fact that no cases of dermatitis have been reported at Kaneohe, which is an enclosed bay adjoining Kailua Beach, nor has any dermatitis-producing alga been found in Kaneohe.

Dr. George Chu, Department of Bacteriology, University of Hawaii, was asked to identify botanically the suspected seaweed. Two botanists,



FIG. 3.—Typical eruption occurring on the scrotum presenting a reddened, raw, blistered surface.

one a specialist in blue-green algae,[4] agreed that it was probably Lyngbya majuscula Gomont. This is a common seaweed, virtually universally distributed throughout the tropics and subtropics, and common on all beaches in Hawaii. Why samples of it from the windward beaches of this one island should cause dermatitis on skin contact, when exposure of comparable degree was presumably occurring on many other beaches, was not, and is not apparent.

Early Washing Preventive

Employing the patch (skin) test* during the summer of 1958 I reproduced experimentally for the first time this dermatitis through exposure of subjects to this alga and thus established Lyngbya majuscula with certainty as the cause of this eruption.[2] Numerous human volunteers repeatedly tested with a pure culture of this alga gave strongly positive reactions. Other varieties of alga collected from the same beaches were excluded as possible causes by negative reaction.

Soap and water bathing as a preventive measure was evaluated during the same time. The reactions of human volunteers to Lyngbya were studied with serial patch tests which were removed at intervals of from one to eight hours. In one group, each skin site was immediately cleansed upon removal of the patch. An uncleansed group served as controls. Delayed reactions (developing subsequently to removal of patch) in the cleansed group were compared with those in the uncleansed control group. These results indicated conclusively the value of bathing as a preventive measure. They suggested that if washing is done up to one hour after contact, there is a good chance of avoiding the dermatitis completely. If it is performed from one to three hours after exposure, the symptoms may be appreciably decreased. If not done until three hours or longer after contact, bathing probably will be of little value.[2]

Investigations also favor the view that sensitization is not involved in the production of these lesions and that it is caused by a primary irritant—hence the name dermatitis escharotica.

[4] Chu, G. W. T. C.: Personal communication.

* Technic of patch test: A small bit of moist seaweed is applied to normal skin of back, covered with a gauze square, which is covered with cellophane and held in place with adhesive. Tests are usually read 24 or 48 hours later. A positive test consists of a dermatitic reaction.

Summary

1. A heretofore unreported dermatitis, observed in persons swimming in the sea on the windward side of the island of Oahu, Hawaii, is described.

2. By employing the patch test I have shown experimentally for the first time that this dermatitis is produced by contact with a blue-green alga which has tentatively been identified as Lyngbya majuscula Gomont.

3. It is believed that this represents the first reported instance of a dermatitis shown to be caused by any marine plant.

4. This eruption is seasonal, having appeared only during June to September 1958 and 1959.

5. The eruption has a characteristic distribution presenting a predilection for dependent body areas covered by closely fitting swimming trunks, athletic supporters, and brassieres.

6. Soap and water bathing (especially of the crotch area) immediately following swimming has been shown experimentally to be of definite prophylactic value.

7. Thorough washing of the bathing suit after swimming to prevent exposure the next time the suit is worn, and cleaning the beaches of accumulated seaweed, are also of value as control measures.

Summario in Interlingua

Un commun alga marin de color blau-verde, Lyngbya majuscula, extensemente distribuite in le oceanos tropic e subtropic, pare esser le prime planta marin producente dermatitis in contacto con le pelle human. Le absentia del necessitate de un previe contacto sensibilisatori, le absentia de un periodo latente ante le declaration del dermatitis, e le apparente susceptibilitate de omne individuo exponite o testate pare excluder le supposition de un allergia e justificar le classification de iste dermatitis como "escharotic" plus tosto que "venenose." Prender un banio intra alicun minutas o un hora post exir ab le oceano resulta in le prevention o mitigation del effecto irritative. Le tractamento es identic con illo de arditura chimic superficial.

Why some strains of Lyngbya majuscula are toxic, and others are not, is still mysterious

A Dermatitis-Producing Alga in Hawaii

Preliminary Report

ALBERT H. BANNER,* Ph.D., Honolulu

LYNGBYA MAJUSCULA Gomont is a nominal blue-green alga, a member of the plant phylum Cyanophyta; its color, however, is usually an olive drab. It grows in the form of long, unbranched hair-like filaments, one cell in diameter. The filaments, without holdfasts, become entangled in other algae, coral, or even sand; and as the cells proliferate, the strands become longer. With strong waves the massed filaments are broken away and carried to become caught on other objects or to be thrown on the shore by the waves. When growing on the bottom or cast up on the shore, the alga usually occurs in characteristic masses like mats of felted hair.



DR. BANNER

Increasing Prevalence

The species is widespread throughout the tropical Pacific and Indian Oceans, occurring often in great abundance from the intertidal zone to a depth of about 100 feet. The first record of it from Hawaii was made in 1912, so presumably it is part of the native flora. However, both by accounts of old fishermen and by observations of trained algologists, it was less abundant before World War II than it is at present; what factors have contributed to its increase are not known.

L. majuscula has never before been reported to cause dermatitis, although it has been reported to have caused deaths of horses feeding on it on beaches of Ceylon. In Hawaii some bathers, and fishermen in whose nets the weed became entangled, have been aware for years that it would cause irritation of the skin, but this property of the seaweed was not called to the attention of local medical workers until the summer of 1958 when large concentrations of a toxic strain were found at Kailua, Oahu.

During the summer of 1958 Dr. George Chu of the University of Hawaii, Dr. Harry L. Arnold, Jr. of Straub Clinic, and Col. Franklin Grauer of Tripler Hospital initiated investigations on the relationship between the alga and dermatitis; their preliminary findings they reported to the Hawaiian Academy of Science. In the spring of 1959 a small investigation was started at the Hawaii Marine Laboratory with a grant from the Honolulu Chamber of Commerce. Personnel working on the problem included Dr. Philip Helfrich, Mr. Robert Morris, Miss Angeline Silva and myself.

Tests for Toxicity

The original test for toxicity in the alga was a patch test on humans, as is reported by Col. Grauer in the accompanying article. In the studies at the Hawaii Marine Laboratory we found the same results could be obtained if the alga were stored in a frozen condition dried by hot air. However, because of the discomfort of the skin tests to the investigator, and because of the possible danger of repetitive tests on the same individual, we have attempted to develop a more objective and less ob-

Contribution No. 118, Hawaii Marine Laboratory.
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jectionable form of assay. Patch tests on experimental animals were unsatisfactory because of the difficulty in keeping the patches intact. Voluntary feeding tests on white mice showed some promise, especially where the dried alga was combined with standard mouse food in pellets. When the mouse ate enough of the test meal, it would develop conjunctivitis, become lethargic, and die within two days. However, as even starving mice did not eat much of the pellet containing toxic Lyngbya and would scatter fragments of the pellet, giving us no control of the amount of alga fed, the test was discarded. Two other tests were found to be satisfactory. In one the ground and dried alga was suspended in a fluid gelatin solution to prevent settling and force fed to mice; with a feeding of 0.3 percent to 1.0 percent body weight the mouse would develop muscular weakness, convulsions, and die within two to three hours with reactions proportional to the toxicity of the sample and the amount fed. In the other test dried alga was extracted with either ethanol or water, the solution diluted with normal saline and injected intracutaneously into rabbits or guinea pigs in amounts equivalent to 0.5 to 0.02 mg of the dried alga. The resulting swelling and erythema was proportional to the toxicity of the sample and its dilution. The results of both tests were found to parallel the results of patch tests on humans. In both tests it was found that if the material fed or injected be concentrated enough, toxic reactions would be obtained in strains not causing human reaction. This appears to indicate that the strains not producing human dermatitis may actually have the toxin in low concentrations.

Toxic Strains in Few Places

In the surveys conducted about Oahu, Molokai, and Kauai it was found that L. majuscula was common on numerous beaches. However, either by human patch test or by guinea pig injections, toxic strains were found only in a few localities. Strongly toxic algae were found in about 80 feet of water off Waikiki and at Laie on the island of Oahu, and at Hanalei on Kauai, while moderately toxic algae were found at Waimanalo, Kailua, Kaaawa, and Makaha on Oahu and at Pilaau on Molokai. In other areas, while the alga might occur in moderate to great abundance, as in Kaneohe and Hanauma Bays, no toxic strains were found.

It is notable that the deep form collected off Waikiki and one small mass of alga collected in Kaneohe Bay, both giving positive reactions in tests, were of red rather than the usual olive drab color. There was no morphological differentiation between the two strains and such a change of color is well-known in the blue-green algae where the normal blue-green pigment, phycocyanin, is reduced to a red pigment, phycoerythrin, under conditions of decreased oxygen tension. There are no differences between the toxic and nontoxic strains of the algae that are considered important enough for a systematic separation into different species.

Relation to Fish Poisoning?

A number of workers have suggested the Ciguatera type of toxicity of fishes—the paralytic toxin that renders certain of the normally desirable species of ground fish, like red snappers, dangerous to eat in limited areas of the tropics—may stem from blue-green algae at the base of the food chain, and some have suggested Lyngbya majuscula, in particular, as the alga that causes the toxicity. In addition, local fishermen from Molokai and Kauai have suggested that Hawaiian mullet poisoning—an intoxication in which the flesh, and especially the head of mullet and surmullet ("nightmare weke"), causes hallucinations and nightmares—is the result of the fish eating this alga. In the current studies no indications have been found of either of these relationships.

Ciguatera and Lyngbya toxins appear to have different solubilities, with that of Lyngbya soluble in water and in alcohol, and that of Ciguatera soluble in alcohol and some of the fat solvents; moreover, the symptoms on feeding to test animals is quite different. It has not been possible to obtain any of the toxic Hawaiian fish for study, but on the basis of the distribution of the toxic strains of the alga and the toxic strains of the fish no relationship is indicated, for the areas where the fish are reputedly the worst do not have highly toxic alga, and where the alga is the worst, the fish are innocuous. However, as our studies are in their initial phases, no positive statements as to possible relationships can be made.

Summario in Interlingua

Lyngbya majuscula es un alga filamentose de color blau-verde que es extensemente distribuite in le tropic Oceanos Pacific e Indian e que es cognoscite in Hawai depost 1912. Ben que illo es commun in multe plagias de Hawai, il es solmente in alicun plagias al latere del vento del insula Oahu que illo ha manifestate intense toxicitate pro le pelle human durante le estates de 1958 e 1959. Solmente casos sporadic de tal toxicitate habeva essite notate in previe annos. Extractos alcoholic del alga es toxic pro le pelle human e etiam post injection in animales. Le substantia molite del alga es toxic post administration oral a muses. Un relation con invenenamento de pisce es considerate como possibile.

Negative bone marrow smears don't rule out leukemia—

not for the first two and a half years, anyway

Nondiagnostic Bone Marrow in Leukemia

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The diagnosis of leukemia is usually established without difficulty by the finding of characteristically hyperplastic bone marrow when the clinical picture and peripheral blood studies are suggestive of the disorder.

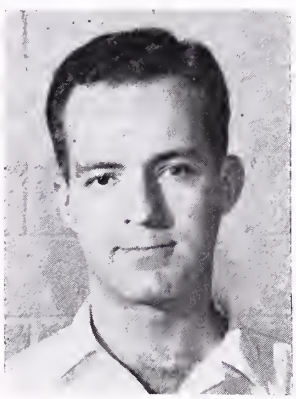
However, the diagnosis of leukemia is not always established with ease. It is the purpose of this paper to call attention to the occasional failure of bone marrow study to indicate early leukemia. Six cases will be reported. All were diagnostic problems which eventually proved to be leukemia, although early bone marrow examinations did not indicate that diagnosis.

The reasons for not obtaining a diagnostic bone marrow specimen early in the course of leukemia will be discussed.

Case Report

CASE 1.—A 53-year-old Portuguese woman was admitted to The Queen's Hospital for the fifth time on February 4, 1954, with complaints of dyspnea on exertion, malaise, and heaviness in the chest for one week. The patient had had weakness and faintness and had been noted to be pale for about five months.

The patient had been in The Queen's Hospital for two days during December, 1953, with the chief complaint of progressive weakness. She was obese and pale. No liver, spleen, or lymph node enlargement was noted. There was pain and hyperesthesia in the fingers, thought to be due to rheumatoid arthritis. Blood count revealed red cells of 3.32 million per mm^3, hemoglobin 10.9 grams per cent, packed cell volume 31 per cent, and white cell count of 2,050 per mm^3 with 1 eosinophile, 1 juvenile, 3 stabs, 45 mature polymorphonuclear leukocytes, and 50 lymphocytes per 100 cells. Urinalysis was normal, as were blood cholesterol, sugar, creatinine, and nonprotein nitrogen. Gastric contents contained a trace of blood but no free acid. The bone marrow showed a diminished production of granulocytes. The patient received blood transfusions and was discharged with the diagnosis of anemia, cause undetermined.



DR. FISHER

The patient was readmitted January 20 to 23, 1954, because of weakness. The pain and paresthesias in the hands were worse. The red blood cell count was 3.85 million per mm^3, hemoglobin 11.6 grams per cent, packed cell volume 34 per cent, and white blood cell count 2,850 per mm^3 with 1 polymorphonuclear leukocyte, 76 lymphocytes (including 6 atypical lymphocytes), and 23 monocytes per 100 cells. The patient was transfused with whole blood and two days later the blood counts were: red count 4.5 million, hemoglobin 15.7, packed cell volume 41 per cent and white blood cell count 4,900 with 7 stabs, 33 polymorphonuclears, 31 lymphocytes, 23 immature lymphocytes, 6 blasts, and 4 nucleated red blood cells per 100 white cells. At this time the diagnosis of leukemia was strongly considered.

The patient was readmitted finally one week later for the symptoms noted above. No lymph nodes, liver, or spleen were palpated. Blood pressure was 154/74, temperature 101.8° F., pulse rate 100 per minute and respiratory rate 26 per minute. Red blood cell count

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was 4 million per mm³, hemoglobin 11 grams per cent, and white blood cell count 148,800 with 3 polymorphonuclears, 7 lymphocytes, 80 immature lymphocytes, and 10 blasts per 100 cells. The patient ran a rapid downhill course and expired on February 7, 1954. Autopsy findings indicated malignant lymphoma (lymphosarcoma of the small cell or lymphoblastic type) with overflow lymphatic leukemia, with the possibility of acute lymphocytic leukemia previously aleukemic or subleukemic.

Comment

This 53-year-old woman had progressive weakness, anemia, and leukopenia, without lymph node, liver, or spleen enlargement. Bone marrow initially showed only a diminished production of granulocytes. The cause of the condition was not known. Two months after her first admission to the hospital she expired, and it was at autopsy that the diagnosis of leukemia was established definitely.

Case Report

CASE 2.—A 70-year-old Caucasian woman was admitted to The Queen's Hospital on May 25, 1954, with the complaints of weakness, tiredness, and easy bruising.

The patient had been in the hospital April 19 to 26, 1954, because of black stools of two days' duration, and gave the history of one year of increasing weakness. Approximately two weeks before admission she had had a virus infection which improved under therapy. A few days before admission she had been started on medication for weakness and then developed the black stools. Two years prior to admission she had had a left radical mastectomy for carcinoma.

Examination revealed a lethargic woman with pallor the only definitely abnormal finding. Laboratory studies revealed a red blood cell count of 1.77 million per mm³, hemoglobin 7.9 grams per cent, reticulocytes 1.4 per cent, platelets 123,900 per mm³, white cell count 10,500 with 2 eosinophiles, 8 stabs, 37 polymorphonuclears, 53 lymphocytes, and 3 nucleated red cells per 100 white cells. Urinalysis was normal, as were blood creatinine, sugar, and nonprotein nitrogen. Cholesterol was 330 mgm per 100 cc, total protein 7.68 grams per cent, albumin 4.12, and globulin 3.56. Basal metabolism rate was plus 10 per cent. Chest x-ray, gastrointestinal series, barium colon enema, and electrocardiogram were all normal. Bone marrow showed slight erythroid hyperplasia but no evidence of pernicious anemia or malignancy.

The patient received blood transfusions, vitamin B complex, B_{12} and liver injections, ferrous sulfate, and other hematinics. On discharge the red count was 4 million, hemoglobin 13.4, and white count 4,800 with 1 stab, 30 polymorphonuclears, and 69 lymphocytes per 100 cells. The final diagnosis was normocytic anemia, cause undetermined.

The patient was readmitted one month later because of weakness and bruising. There were palpably enlarged cervical lymph nodes, and the liver edge was three fingerbreadths below the costal margin. The spleen was not felt. Gingivitis developed soon after admission. On admission the red cell count was 2.16 million per mm³, hemoglobin 8.4 grams per cent, packed cell volume 24 per cent, platelets 41,000 per mm³, reticulocytes 0.4 per cent, white cell count 79,000 per mm³ with 1 basophile, 5 eosinophiles, 5 promyelocytes, 6 myelocytes, 9 juveniles, 23 stabs, 36 polymorphonuclear leukocytes, 10 lymphocytes and 5 monocytes per 100 cells. The bone marrow was diagnostic of acute myelogenous leukemia. Before discharge on June 19, 1954, the white cell count was 90,000 per mm³ with 6 eosinophiles, 2 promyelocytes, 16 myelocytes, 15 juveniles, 7 stabs, 9 polymorphonuclear leukocytes, 12 lymphocytes, 29 monocytes, and 4 blasts per 100 cells. The marrow cells stained peroxidase-negative. The patient was discharged to be treated elsewhere, with the final diagnosis of acute myelogenous leukemia (Naegeli type).

Comment

This seventy-year-old woman was admitted to the hospital because of progressive weakness for one year, and was found to have anemia and thrombocytopenia, unassociated with lymph node, liver or spleen enlargement. The anemia, whose cause was unknown, proved refractory, responding only temporarily to blood transfusions. The initial bone marrow smears showed only slightly increased erythropoiesis. One month later there were lymph node and liver enlargement, together with leukocytosis, anemia and thrombocytopenia, and the bone marrow was then diagnostic of leukemia. The subsequent course of this patient is not known.

Case Report

CASE 3.—A 31-year-old Chinese woman was admitted to The Queen's Hospital on September 19, 1957, with the chief complaints of fever and weakness of eleven days' duration. The patient had thought she had the 'flu,' and consulted her physician eight days before admission, and was treated with erythromycin. The fever persisted with elevations of temperature to 102° F. There were generalized myalgias, headache, and malaise. The patient had pallor and easy bruising over a period of several months.

Physical examination revealed a well nourished and well developed Chinese woman in no distress. Blood pressure was 110/70 mm. mercury; pulse rate 100 per minute; respiratory rate 20 per minute; and temperature 103° F. There were no abnormal findings in the skin; no adenopathy; no palpable abdominal organs; and no abnormal findings in the lungs. There was a soft systolic murmur in the pulmonic area.

Laboratory examinations on admission: red cell count 3.08 million per mm³; hemoglobin 8.1 grams per cent; packed cell volume 27 per cent; platelet count 39,000 per mm³; white cell count 2,350 with 1 juvenile, 4 stabs, 27 polymorphonuclear leukocytes, 10 lymphocytes, and 1 monocyte per 50 cells. Seven lymphocytes were atypical. Urine had a specific gravity of 1.009, with a faint trace of protein, and 10-12 white cells per high power field. There were no febrile or cold agglutinins, and no lupus erythematosus cells on special preparations. Blood was sterile. Blood type was B, Rh positive. Chest x-ray revealed a faint peribronchial infiltration in the left lower lobe and lingula.

Aspiration of sternal bone marrow revealed hypocellular smears, partly due to hemodilution. There was a normal distribution of cells of normal maturation, and no evidence of leukemia.

The clinical picture was initially interpreted as being one of severe granulocytic depression secondary to a viral infection. Two days after admission there was enlargement of cervical lymph nodes. There was also resistance in the left upper quadrant of the abdomen, suggestive of splenomegaly. Systemic lupus erythematosus and leukemia were considered diagnostic possibilities. On the third hospital day a few blasts were seen on smears of peripheral blood and of marrow. The marrow was still hypoplastic with a few islands of anaplastic cells showing maturation into monocytes or atypical histiocytes. Although the marrow was still hypocellular, it was thought that this might be the early stage of leukemia, and the patient was started on steroid therapy.

Two days after prednisolone, 15 mgm every six hours, was started, the temperature came down. However, the spleen was noted to be enlarging during this time, as were posterior cervical, axillary, and inguinal lymph nodes. Two days later there was a sudden rise in temperature and the patient began to have paresthesias of the palms and soles, together with marked diaphoresis. The spleen, liver, and lymph nodes continued to enlarge.

Two weeks after admission, and one week after steroid therapy was started, the white cell count was 1,600 per mm^3 with 8 juveniles, 11 stabs, 48 polymorphonuclear leukocytes, 16 lymphocytes, and 17 abnormal lymphocytes per 100 cells. Platelet count was 77,700 per mm^3, hemoglobin 9 grams per cent, and red cell count 3.7 million per mm^3.

Nine days later there was a low-grade fever with daily spike, but the patient presented no complaints. The iliac crest marrow again showed hemodilution and hypocellularity. There were individual cells and occasional groups of cells in blast stage, and the marrow was considered highly suggestive of leukemia. Four days later the marrow was still hypocellular. The patient had received blood transfusions and antibiotics, as well as symptomatic therapy.

About one month after admission, and six weeks after onset of illness, the marrow showed increased cellularity for the first time and was diagnostic of acute stem-cell leukemia. The patient ran a rapid downhill course and expired on November 2, 1957.

Comment

This thirty-one-year-old woman was sick for six weeks with fever, lymphadenopathy, hepatosplenomegaly, pancytopenia, and a hypocellular bone marrow. Early in the course this was thought to be a toxic state secondary to viral infection, but systemic lupus erythematosus and leukemia were also considered strong diagnostic possibilities. As the clinical picture developed, the diagnosis of leukemia was considered the best possibility. However, it was not until six weeks after onset that the bone marrow became diagnostic of acute leukemia, and after that time the patient continued rapidly downhill with death about one week later.

Case Report

CASE 4.—A 55-year-old Japanese woman was admitted to The Queen's Hospital for the seventh time on August 15, 1954, with the chief complaints of chest pain and dyspnea of several hours' duration. The patient had been discharged from the hospital one week earlier after a five-week hospitalization with the final diagnosis of acute sialadenitis of the parotids and of the left submaxillary salivary gland.

The admitting complaint during the previous admission was pain in left side of the neck. There was swelling and tenderness of the involved salivary glands. The liver edge was two fingerbreadths below the costal margin, but there was no detectable enlargement of the spleen or peripheral lymph nodes. Initial blood count revealed red cell count of 3.2 million per mm^3, hemoglobin 9.3 grams per cent, reticulocytes 8.8 per cent, platelet count 47,600 per mm^3, and white cell count of 87,000 per mm^3 with 4 stabs, 72 polymorphonuclear leukocytes, 22 lymphocytes, and 2 eosinophiles per 100 cells. Urinalysis was normal, as were urine and serum amylase levels and heterophile agglutination titer. Chest x-ray was normal, but x-rays of paranasal sinuses revealed signs of bilateral maxillary and frontal sinusitis.

Bone marrow study revealed some hyperplasia of the granulocytic series, but was not diagnostic of any blood dyscrasia. After one week of therapy with antibiotics and sedatives, the white cell count decreased to 10,100 per mm^3 with 59 polymorphonuclear leukocytes, 40 lymphocytes, 1 monocyte, and 2 nucleated red cells per 100 white cells. There was an initial two-week downhill course after which the patient improved gradually.

During the week at home between the sixth and seventh hospital admissions the patient remained weak, was anorexic, and her gums bled easily. During the night before the seventh admission she developed anterior chest pain and dyspnea.

Previous hospitalizations were for acute upper respiratory infection in 1938; cystitis and bilateral pyelonephritis in 1944; acute tracheobronchitis in 1949; and dilatation of urethral stricture, cystitis and pyelonephritis in 1950.

Physical examination on the seventh admission revealed a well nourished and well developed Japanese woman who was in no distress but who was apprehensive. Blood pressure was 120/72, temperature 99.4° F., pulse rate 100 per minute, and respiratory rate 16 per minute. There was pallor, especially of the mucous membranes; moderate injection of the pharynx; slight swelling of the parotid glands; tender liver with edge two fingerbreadths below the costal margin; and right costovertebral angle tenderness.

Admission laboratory studies revealed red cell count of 2.9 million per mm^3, hemoglobin 9.4 grams per cent, platelets 15,660 per mm^3, and white cell count of 39,700 with 1 myelocyte, 4 juveniles, 13 stabs, 50 polymorphonuclear leukocytes, and 32 lymphocytes per 100 cells. Urinalysis and mumps complement fixation test were normal. Chest x-ray revealed mediastinal node enlargement.

A bone marrow examination was diagnostic of acute monocytic leukemia. During the next month the platelet count, red cell count, and hemoglobin remained low. The white cell count went through a minimum of 3,800 and then rose preterminally to 95,000 per mm^3 with 51 per cent monocytes. The patient received blood transfusions and hydrocortisone. Multiple petechiae developed in the skin and mucous membranes. Liver, spleen, and peripheral lymph nodes enlarged. The pa-

tient became dyspneic, had chest and abdominal pains, a hectic fever curve, and ran a rapid downhill course to her demise on October 7, 1954. No autopsy was performed.

Comment

This fifty-five-year-old woman's terminal illness presented with sialadenitis, leukocytosis, anemia, and thrombocytopenia. The bone marrow initially was not diagnostic of any severe blood dyscrasia. It was not until about six weeks after the onset of illness that the bone marrow was diagnostic of leukemia, and the patient died less than two months later.

Case Report

CASE 5.—A 30-year-old Japanese woman was readmitted to The Queen's Hospital in coma on October 25, 1957. The patient was known to have acute leukemia.

The patient's first admission to The Queen's Hospital was from March 20 to April 7, 1957, with the final diagnosis of retained secundines and pancytopenia. She had aborted on February 9, 1957, and was given a blood transfusion at another hospital, at which time the red blood cell count was 3.6 million per mm^3 and the hemoglobin was 10.8 grams per cent. The patient continued to have vaginal bleeding after the miscarriage and also developed fever, chills, diaphoresis, anorexia, and malaise. For five days prior to the first Queen's Hospital admission there had been generalized muscle aching and an ecchymosis on the right shoulder. The liver edge was found to be two fingerbreadths below the costal margin. There was no detectable enlargement of spleen or peripheral lymph nodes.

Laboratory examinations on first admission revealed red cell count of 3.18 million per mm^3, hemoglobin 9.4 grams per cent; packed cell volume 28 per cent; white cell count 1,700 per mm^3 with 4 stabs, 19 polymorphonuclear leukocytes, 25 lymphocytes, and 2 monocytes per 50 cells; corrected sedimentation rate 10. Urine had a specific gravity of 1.020 and contained 1-plus protein, and 6-10 white cells per high power field. Blood was sterile. There was no increase of febrile or cold agglutinins. No lupus erythematosus cells were seen on several preparations, nor any malarial forms. Chest x-ray was normal, and intravenous pyelogram revealed changes of chronic right pyelonephritis.

Bone marrow was hypoplastic, as judged by smears of aspirated marrow. Bone marrow biopsy revealed mild to moderate hypoplasia with apparent disturbance of maturation judging by decreased numbers of mature neutrophiles and a relative increase of monocytes and immature forms. The marrow was considered compatible with toxic suppression and agranulocytosis.

The patient was started on prednisolone, 15 mgm three times daily. Two days later the white count was 2,000 and platelet count 136,500 per mm^3, and hemoglobin 12.6 grams per cent (after transfusion). An occasional atypical lymphocyte was seen on peripheral blood smear. The following day the platelet count was 103,600, reticulocytes 0.3 per cent, and white cell count 1,200 per mm^3. On April 6 the white count was 1,550 with 44 polymorphonuclear leukocytes, 46 lymphocytes, 2 monocytes, 2 basophiles, 2 eosinophiles, and 2 stabs per 100 cells; red cell count 4.64 million per mm^3 and packed cell volume 41 per cent.

Dilatation and curettage of the uterus was performed, with the pathologic diagnosis of degenerating placenta. The patient received blood transfusions, oral hematinics, and antibiotics. There was a hectic fever curve for two weeks, with temperatures to 104° F., before clinical improvement occurred.

The patient was kept on steroid therapy after the first hospital admission, and developed fever with temperatures of 102° F. She was readmitted to hospital from June 7 to June 29, 1957. Physical examination was not remarkable except for the fever.

Laboratory studies during the second admission revealed urinalysis normal; stool contained Salmonella; hemoglobin 12.1 grams per cent; red blood cell count 4.32 million per mm^3; platelet count 129,600 per mm^3; white cell count 1,700 per mm^3 with 38 polymorphonuclear leukocytes, 42 lymphocytes and 20 stabs per 100 cells. Bleeding and clotting times, clot retraction, red cell fragility, lupus erythematosus preparations, blood culture, VDRL, creatinine, nonprotein nitrogen, fasting blood sugar, serum bilirubin, serum albumin and globulin, Kunkel, BSP, alkaline phosphatase, and phosphorus were all normal, as was an upper GI series.*

The patient was treated with chloramphenicol, and improved. The final diagnoses were fever of unknown etiology associated with leukopenia, mild anemia, and thrombocytopenia, and probable carrier state of Salmonella Group E.

The patient was kept on steroids and iron therapy. Liver and spleen increased in size; platelets, red cells and white cells decreased in numbers and immature white cells appeared in the peripheral blood; and for one week prior to the third admission the patient developed feverishness, abdominal pains, and extreme fatigue. The third admission was from September 11 to 17, 1957. On admission the blood pressure was 110/70; there were generalized petechiae and purpuric areas; the liver edge was three fingerbreadths below the costal margin and the spleen was estimated to be twice normal size. Red cell count was 3.3 million per mm^3; hemoglobin 10.2 grams per cent; packed cell volume 32 per cent; white cell count 1,950 per mm^3 with 23 stabs, 47 polymorphonuclear leukocytes, and 30 lymphocytes; platelet count 52,800 per mm^3; urine normal except for trace of protein; serum uric acid 3.7 mgm per cent; albumin 4.5 and globulin 2.5 grams per cent.

The bone marrow contained predominantly blasts which stained peroxidase-negative. Fresh whole blood transfusions were given and prednisolone was increased to 80 mgm daily. The final diagnosis was acue leukemia, type undetermined.

The fourth and final admission was from October 25 to expiration on November 10, 1957. The patient had convulsed and lapsed into coma and was brought to hospital where the course was downhill. Preterminally the red count was 3.98-4.16 million per mm^3, hemoglobin 12 grams per cent; packed cell volume 35 per cent; white count 5,250 per mm^3 with 8 blasts, 8 juveniles, 35 stabs, 42 polymorphonuclear leukocytes, 5 lymphocytes, and 2 basophiles; and platelet count 79,600 per mm^3. The white count terminally sank to 950 per $mm.^3$

Comment

This 30-year-old woman came to the hospital because of continued vaginal bleeding due to re-

* She was a private patient. The hospital assumed part of the cost of these studies.—ED.

TABLE 1.—*Summary of Clinical Features*

CASE	AGE	SEX	EARLY CHARACTERISTICS	DURATION OF INDETERMINATE STAGE	DURATION OF LIFE AFTER LEUKEMIA DIAGNOSED	TYPE OF LEUKEMIA
1.	53	F	weakness. anemia. leukopenia. marrow : decreased production of granulocytes.	7 mos.	diagnosed postmortem	acute lymphoblastic
2.	70	F	weakness. anemia. thrombocytopenia. marrow : increased erythropoiesis.	1 yr. 1 mo.	no followup	acute myelogenous
3.	31	F	fever. pancytopenia. lymph node, liver, spleen enlargement. marrow : hypocellular.	6-7 wks.	1 wk.	acute stem cell
4.	55	F	sialadenitis. anemia. thrombocytopenia. leukocytosis. marrow : unremarkable.	7 wks.	7 wks.	acute monocytic
5.	30	F	pancytopenia. hepatosplenomegaly. marrow : hypoplastic.	6 mos.	2 mos.	acute stem cell
6.	71	M	refractory anemia. marrow : hypoplastic.	2 yrs. 6 mos.	3 wks.	acute myeloblastic

tained placenta, two months after a miscarriage, and was found to have pancytopenia with hepatomegaly. The bone marrow was hypoplastic. There was a period of at least six months with known pancytopenia, refractory anemia, and increasing hepato-splenomegaly before the diagnosis of leukemia was confirmed by marrow studies. Once the marrow became diagnostic of leukemia, the patient continued downhill and expired within two months.

Case Report

CASE 6.—A 71-year-old Caucasian man was admitted to The Queen's Hospital on March 21, 1955, with the chief complaints of dyspnea and chest pain of two days' duration. There was also left upper quadrant abdominal pain on deep breathing, with radiation to the left shoulder. The patient had been followed prior to admission for progressive and refractory anemia over a period of several years. Bone marrow had shown total hypoplasia in September, 1954. The patient had anorexia, occasional ankle edema, general weakness, and easy bruising for over one year. The day of admission the temperature rose to 101.4° F.

Past history included typhoid fever during childhood; acute infectious gastroenteritis in 1950, treated with chloramphenicol; and removal of a ruptured semilunar cartilage of the knee in 1952. In 1952 the white cell count was 6,000 per mm^3 with 68 polymorphonuclear leukocytes, 26 lymphocytes, and 6 eosinophiles, and hemoglobin was 14 grams per cent.

Physical examination on admission to the hospital in 1955 revealed a moderately pale, weak, elderly Caucasian man. There were small hemorrhages into the hard palate, and multiple ecchymoses on the skin. There were bilateral basilar rales and some dullness. Blood pressure was 136/50 mm mercury. The second pulmonic sound was louder than the second aortic heart sound, and no murmurs were heard. The liver edge was seven cm below the costal margin, and there was tenderness in the left upper quadrant where the spleen tip was palpable.

Laboratory examinations on admission: red cell count 1.86 million per mm^3, hemoglobin 6.1 grams per cent, white cell count 85,000 per mm^3 with 10 blasts, 4 promyelocytes, 20 myelocytes, 26 juveniles, 32 bands, and 8 mature polymorphonuclear leukocytes. EKG was normal. Urine Sp.G. was 1.028, with trace of protein, 10-15 white cells, 6-10 red cells, and an occasional fine granular cast.

The patient was transfused with type A blood, Rh positive. During the following week the spleen became less tender but larger, and the liver also enlarged. Pinpoint petechiae appeared over the entire body. The patient developed diarrhea and glossitis, and became dehydrated. The white count rose to 172,000 per mm^3.

On April 6 the patient was started on amethopterin (Methotrexate) 5 mgm daily. On the drug the white count went down to 18,200 and the platelets went from 9,650 to 16,680 without clinical improvement. There was bloody vomitus, diarrhea, and hematuria, and the patient expired on April 10, 1955. The final diagnosis was myelobastic leukemia.

Comment

This 71-year-old man had been treated for a refractory anemia for several years, and six months before the diagnosis of leukemia was established there had been a bone marrow study interpreted as showing total hypoplasia. On admission to the hospital there was increasing hepatosplenomegaly, petechiae, and ecchymoses. The patient died about three weeks after the diagnosis of leukemia was made.

Discussion

The six cases reported herein were among a total of forty-three cases of leukemia treated in The Queen's Hospital within the past eight years. Thus, almost one case in seven could not be diagnosed initially as leukemia, although hematologic studies were performed. In the other thirty-seven cases of leukemia the diagnosis was made without significant difficulty at the start of clinical illness.

The salient features of the six cases are indicated in Table 1, and are summarized below. All were cases of acute leukemia. The initial impression in cases number one (lymphoblastic), two (myelogenous), and six (myeloblastic) was of anemia of unknown cause. In case number three (stem cell) the initial impression was of a toxic state due to viral infection although systemic lupus erythematosus and leukemia were considered. Case number five (stem cell) also was initially considered to be a toxic state with marrow depression and fever, of unknown origin. Infection was originally thought to be the cause of the leukocytosis, anemia, and thrombocytopenia in case number four (monocytic leukemia) which presented as sialadenitis.

The duration of illness prior to the diagnosis of leukemia ranged from about one and one-half months to two and one-half years. After the diagnosis of leukemia was made, death followed in from one week to two months. The case of acute lymphoblastic leukemia was diagnosed postmortem. There was no follow-up of the patient with acute myelogenous leukemia.

Each of the six cases had an initial anemia, more or less refractory to therapy. There was leukopenia in the case of lymphoblastic leukemia and in the two cases of stem cell leukemia. There was leukocytosis in the case of monocytic leukemia. Thrombocytopenia existed in four cases: the myelogenous, the monocytic, and the two cases of stem cell leukemia.

The bone marrow was initially hypoplastic in the two cases of stem cell leukemia and in the case of myeloblastic leukemia. The marrow was initially unremarkable in the other three cases.

There was initial enlargement of lymph nodes, liver, and spleen in one case of stem cell leukemia, and of liver and spleen alone in the other case of stem cell leukemia.

The literature reflects an increasing awareness of atypical forms of onset of leukemia, as well as the failure of bone marrow study to establish the diagnosis of leukemia during the preleukemic phase.[1]

Thoroughly studied yet puzzling cases with no clear-cut diagnosis can terminate as diagnosable leukemia, as in the two cases reported by Rowen.[3]

The six cases of leukemia reported by Meacham and Weisberger[4] were initially thought to be hypersplenism, with various combinations of anemia, neutropenia, thrombocytopenia, and normal or hyperactive bone marrows. Splenectomy was of no value in these cases.

Block and Jacobson,[5] and Bernard and Boiron,[6] reported cases of leukemia preceded by unexplained, refractory anemias. The case reported by Andre[7] had an unexplained neutropenia for 18 months, followed by an unresponsive anemia. The bone marrow was hypoplastic in this case before leukemia was diagnosed.

A case of aplastic anemia which was followed for four and one-half years developed leukemia terminally, as reported by Mohler and Leavell.[8]

Dreyfuss and Bessis[9] reported 17 cases of leukemia preceded by myeloid aplasia, marked anemia, and pancytopenia. In these cases the bone marrows were variable and not diagnostic.

In the above reported cases there were the inconstant early findings of lymphadenopathy and hepatosplenomegaly, and symptoms of feverishness, weakness, malaise, bleeding tendency, or tendency to infections.

It is interesting to speculate about why the bone marrow is not always hyperplastic at the beginning of a case of leukemia, during the so-called preleukemic state.

Aside from errors in diagnosis or the coincidental development of leukemia in the course of an unrelated disease, several possible reasons exist.

One major reason is that early in the course of leukemia the bone marrow hyperplasia is localized rather than diffuse, and the hyperplastic areas may be missed in attempts at marrow aspiration or biopsy. Whatever the etiologic factors of leukemia may be, the neoplastic process is unifocal or multifocal rather than uniformly diffuse through the bone marrow in its onset or subsequent course. The possibility of missing pathologic changes in limited biopsy specimens is of course well known, and exists in conditions other than leukemia.

---

[1] Williams, M. J.: Myeloblastic leukemia preceded by prolonged hematologic disorder, Blood 10:502-509 (May) 1955. Wintrobe.[2]

[2] Wintrobe, M. M., and Mitchell, D. M.: Atypical manifestations of leukemia, Quart. J. Med. 9:67-90 (Jan.) 1940.

[3] Rowen, M. J.: Problem in the diagnosis of leukemia, Ann. Int. Med. 46:907-914 (May) 1957.

[4] Meacham, G. C., and Weisberger, A. S.: Early atypical manifestations of leukemia, Ann. Int. Med. 41:780-797 (Oct.) 1954.

[5] Block, M., Jacobson, L. D., and Bethard, W. F.: Preleukemic acute human leukemia, J.A.M.A. 152:1018-1028 (July 11) 1953.

[6] Bernard, J., and Boiron, M.: The preleucoblastic anemias of acute leukemias, Sang. 25:797-825 (No. 8) 1954.

[7] Andre, L., Marty, J., Respe, R., and Morichman-Beuchant, J.: A case of acute leukemia preceded by neutropenia, of 18 months duration. Bull, et mém. Soc. méd. hôp. de Paris, 69:419-421 (May 15) 1953.

[8] Mohler, D. N., and Leavell, B. S.: Aplastic anemia—An analysis of 50 cases, Ann. Int. Med. 49:326-362 (Aug.) 1958.

[9] Dreyfus, B., and Bessis, M.: Acute leukemia preceded by myeloid aplasia, Sang. 25:787-797 (No. 8) 1954.

A second reason is that the initial foci of leukemia may be extramedullary[10] and the bone marrow not involved until later in the disease. Leukemia is a disease of reticuloendothelial tissue, and it may have an extramedullary onset in certain cases. Lymphocytic leukemia originates in lymphoid tissue. Indeed, lymphocytic leukemia is one type where bone marrow study is not needed to establish the diagnosis, and where the absence of marrow hypercellularity does not exclude the diagnosis if other clinical features are strongly in favor of it. It is a difficult, if not impossible, problem to differentiate lymphocytic leukemia from lymphosarcoma with lymphocytic overflow.[11] This problem was present in our case one.

A third reason is that in certain cases of leukemia the onset may be with bone marrow hypoplasia rather than hyperplasia. It is this preleukemic state which is most intriguing and most perplexing. A perhaps analogous condition obtains in precancerous atrophic lesions giving rise to malignancies, such as kraurosis and atrophic gastritis. In these atrophic lesions, microscopic areas of hyperplasia can be demonstrated from which the malignancies seem to evolve. In our case three (stem cell leukemia), although the marrow initially was generally hypoplastic, islands of anaplastic cells were seen, and in subsequent marrow aspirations these islands became larger and more frequent and the cells in them resembled the cells which eventually filled the marrow. Agnogenic myeloid metaplasia, a condition within the spectrum of the myeloproliferative diseases,[12] is considered potentially preleukemic despite apparent marrow hypoplasia. It is advisable to scrutinize bone marrow smears or sections carefully for groups of atypical or young cells, especially if the marrow is hypoplastic.

Conclusion

Unfortunately, not enough is known about leukemia at the present time to enable one to make the diagnosis early in the atypical case. More effective and less heroic measures, such as properdin neutralization and bone marrow transfusion may prove to be,[14] can replace the futile measures thus far employed in the treatment of terminal leukemias only when the diagnosis is made early. For the present, leukemia should be suspected in any case of hematologic abnormality which is not readily explained, or which does not respond as expected to therapy, with particular attention to refractory anemias. The diagnosis of leukemia should not be discarded in the face of nonconfirmatory bone marrow studies, because of the possibility that one is faced with a preleukemic state.

Six cases are presented which illustrate some of the difficulties encountered in making a diagnosis of leukemia before the marrow becomes characteristically hyperplastic. In the preleukemic phase of leukemia the bone marrow may be normal, it may show only minor and nonspecific changes, or it may be hypocellular as it was in half of our cases. Refractory anemia is frequently an outstanding feature. Enlargement of lymph nodes, liver, or spleen is inconstant. The preleukemic state in our cases lasted from six weeks to two and one-half years before the marrow became hyperplastic and the diagnosis of leukemia was established. A selected review of the literature on the preleukemic phase of leukemia is presented.

It is suggested that nondiagnostic bone marrow can be obtained early in leukemia because of one of three reasons: early changes may be localized and missed by marrow aspirations; the early changes may be extramedullary and not present in the marrow at all; or the marrow may be hypocellular in certain cases of leukemia before it becomes hyperplastic.

Summario in Interlingua

Es reportate sex casos de leucemia in que le symptomas del morbo durava pro periodos de inter sex septimanas e duo annos e medie ante que frottis de medulla ossee permitteva le establimente de un diagnose positive. Le plus prolongate periodos non-diagnostic occurreva in un caso de acute leucemia myeloblastic e in un caso de acute leucemia myelogene. Le plus curte periodos nondiagnostic occurreva in un caso de acute leucemia de cellulas de origine e in un caso de acute leucemia monocytis. Periodos non-diagnostic de duration intermediari occurreva in un secunde caso de acute leucemia de cellulas de origine e in un caso de acute leucemia lymphoblastic. Es proponite tres explicationes possibile: (1) Origine extramedullar del leucemia; (2) origine focal intra le medulla, con le focos non incontrate per le aspiration; o (3) un phase hypoblastic al initio del morbo.

121 E. Northfield Rd. (Dr. Fisher), Livingston, N. J.

[10] Danopoulos, E., and Angelopoulos, B.: Der extramedulläre Beginn der akuten Leukämien; Beobachtungen und Schlusse bei 3 eigenen Fallen, Med. Klin. 49:1947-1950 (Dec. 3) 1954.

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[12] Dameshek, W.: Some speculations on the myeloproliferative syndrome, Blood 6:372-375 (April) 1951. Peace.[13]

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The President's Page



DR. NISHIGAYA

Bauer

The Hawaii Medical Association was ably represented at the 108th Annual Meeting of the American Medical Association held in Atlantic City, June 8-12, 1959, by Drs. Arnold, Moore, Miss Lee McCaslin, and your President.

The highlights of the meeting have been given you in the last issue of the HAWAII MEDICAL JOURNAL by Drs. Arnold and Moore. One not mentioned was the appearance of President Eisenhower, who addressed the assembly at the inauguration of Dr. Louis Orr as the 113th President of the AMA.

Greatest press coverage was received on the AMA stand as reported by the Commission on Medical Care Plans. Headlines in the Eastern press screamed of AMA's "comedown" from its previous firm stand on panel medicine.

The AMA, I believe, does not condone such practice, but realizing the problems confronting many local medical societies, eased its stand so that each constituent society could cope with its problems in its own way. The following is what the House of Delegates approved:

"The AMA believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the AMA vigorously supports the right of the individual to choose between these alternatives."

The First National Conference of the Joint Council to Improve the Health and Care of the Aged was held on June 12-13, 1959, in Washington, D. C. Hawaii again was well represented with Drs. N. Sloan, V. Sloan, Peter Kim, and myself.

The conference revolved around the increasing national interest in the care of the aged (over 65) who at present number 14.5 million, and by 1975 is estimated to reach 22 million. President Eisenhower has called for a White House Conference on this subject for January, 1961, and preliminary studies are being made to help solve the problem. Threats of government intervention have already been made.

The one factor which impressed me was that the problem is basically economic and that the *physician's fees* play a very minor and insignificant role in the total care of the aged. However, the physician's role is significant and he should and must contribute to the solution of this great problem. However, we must think and act cautiously and not set bad precedents for the future.

T. Nishigaya, M.D.

P.S. I have received a formal invitation for the members of the HMA to attend the sessions of the Western Conferences of Prepaid Medical Service Plans, to be held in Honolulu November 8-12, 1959. Drs. Frazier, Nance, West, Mr. Kennedy, and myself have been fortunate to attend one of these conferences. We can all attest that they are worthwhile and worth attending.

Don't forget—November 8-12, 1959, Western Conference Prepaid Medical Service Plans.

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[EDITORIALS]

The National Foundation for—Everything?†

A disturbing paradox in the voluntary health agency business, for many years, has been the fact that the largest income has been enjoyed by the agency with the smallest problem, namely, the National Foundation for Infantile Paralysis.

Now that the polio problem is getting even smaller, this agency has renamed itself The National Foundation, and its fund drive the "New" March of Dimes, and it has announced that it will now concern itself also with birth defects and rheumatoid arthritis.

Beneficiaries under this new program must be capable of being helped by treatment, and ineligible for adequate services provided by other agencies, and (like nonpriority polio victims) under 19 years of age. They must have either progressive hydrocephalus, encephalocele, or myelomeningocele, symptomatic spina bifida, or active rheumatoid arthritis.

Prohibited chapter expenditures are: doctors' fees; hospital expenses otherwise insured against or paid for; hospitalization over 180* days the first year or 150* days annually thereafter; replacement or repair of damaged or worn out appliances (outgrown appliances are replaceable); treatment of unrelated concurrent disease; expenses incident to change of climate, summer camps, or vacations; special duty nurses; and treatment not approved by the local Medical Advisory Committee.

This patient care program is a move into areas already covered in varying degrees by existing agencies: Shriners' Hospitals (up to age 16), the Bureau of Crippled children (to age 21), the Bureau of Vocational Rehabilitation (to age 18), and the National Society for Crippled Children and Adults (any age). Congenital heart disease is not covered now, but it is a "birth defect" and its exclusion is solely a matter of current policy.

With the patient care program goes, as with polio, a generous program in professional education and research. A recent Foundation announcement says that 1959 authorizations already exceed $4,000,000 in grants for research and education in the field of central nervous system disorders. Over $188,000 has been allocated to nursing education and nearly $60,000 to the National Association of Social Workers.

Is there plenty of money available for this? Well, the 1959 March of Dimes raised over $31,000,000. Yet the July issue of the *National Foundation News* says "CHAPTER AID FUNDS WIPED OUT IN JUNE." The article goes on to say that less than half the money requested by 415 chapters as advances needed to help pay for polio care was available in the Chapter Aid Fund set up for such requests. Texas chapters, the article said, "owe over half a million dollars for polio care."

This vividly—if unnecessarily—highlights the fact that polio is not licked yet, not by a long (or Salk) shot. The main aim of The National Foundation—the control and eradication of poliomyelitis—has not been accomplished. Funds donated to this organization (as they will be) in the expectation that they will be spent on polio should not be spent on other diseases.

On the face of it, this "new look" appears to be a manifestation either of embarrassment at having so much money to spend, or of the instinct for self-preservation, which may be inherent in agencies as well as in people, and in private agencies as well as in government bureaus. We can understand it, but we cannot approve of it, and we will not support it.

† See Correspondence section for an official comment on this editorial.

* 60 days the first year, and 30 annually thereafter, for arthritis; 90 days for birth defects, and 60 annually thereafter; 180 days the first year, and 150 days annually thereafter for poliomyelitis.

Animals and Human Disease in Hawaii

There are nearly 100 diseases (they are called zoonoses) that may on occasion be transmitted from animals to humans; there are some human diseases that are transmitted only by animals; and there are some animal diseases that resemble, and may shed light on, some human diseases.

Some of the more commonly recognized zoonoses: bovine tuberculosis, cysticercosis, brucellosis, rabies, trichinosis, and leptospirosis, either are not known to infect humans in Hawaii, or are reported infrequently. This is due either to strictly enforced quarantine measures, control and eradication programs in animals or difficulty of diagnosis in humans. The dynamic and constantly changing pattern of host-parasite relationships continues to produce new knowledge of zoonoses. Certain arthropod-borne viruses, visceral larva migrans and insectivorous bat rabies are a few examples of newly recognized "emerging zoonoses."

Dr. Gordon D. Wallace, Consultant in Comparative Medicine and Veterinary Public Health in the U. S. Public Health Service, currently on loan to our Health Department, is carrying out investigations in these fields in close cooperation with the Territorial Department of Agriculture and Forestry.

One object of his concern is virus encephalitis, the mosquito vectors of which are present in Hawaii, while its causative viruses surround the Pacific Ocean. Eight recent suspected human cases, three of them fatal, have been found by Dr. Robert Kissling, the Health Department's new virologist, to be serologically negative, and no virus has been isolated from them as yet. Studies for arthropod-borne virus antibodies in humans and for possible reservoirs of infection in wild birds are already under way.

Nocardial mastitis in a dairy herd is also being investigated, as well as a localized outbreak of mastitis due to Staphylococcus phage type 80/81 in another herd associated with human infection.

The problem of atypical acid-fast bacilli in relation to tuberculosis is another target for Dr. Wallace's inquiries. Dermatologists here have long suspected that some skin infections are caused by these bacilli. It has recently been discovered that AAFB causing chronic pulmonary disease in humans closely resemble avian T.B. bacilli found in swine.

Naalehu disease, which resembles human arteriosclerosis in some respects and seems to occur in cattle eating certain kinds of fodder, is to be studied by Dr. Ernest Willers, Dr. Wallace, and others. It is anticipated that a research grant supporting this project will be forthcoming from the National Heart Institute.

Infant Mortality

One of the factors in the decrease of maternal deaths the country over has been the objective studies of individual deaths by local medical society committees—so-called Maternal Mortality Study Committees. Hawaii's ten-year-old Committee has been a Territorial one and has also served another function, i.e., Advisory Committee to the Bureau of Maternal and Child Health (of the Department of Health). Members serve for three years and terms are staggered to promote continuity.

Approximately a year ago the Committee reorganized to include studies of infant deaths. Previous attempts had fallen by the wayside for various reasons. A sub-committee screens information extracted from death and birth certificates, queries physicians regarding details of the case—both obstetrical and pediatric—and summarizes it for the general Committees. Deaths selected for study usually have aspects of interest to pediatricians, obstetricians, general practitioners, and pathologists. Occasional cases have interest for anesthesiologists and internists. A letter to the physician (or physicians) concerned with the case is sent by the Chairman who summarizes committee discussions in regard to preventability. All committee studies are carried on anonymously.

The infant death rate in the U. S. has steadily declined until three years ago when the rate began to increase. The numbers for the whole U. S. are statistically significant. There is a slight trend upward in Hawaii which is not statistically significant as yet because of the much smaller numbers involved. However, it is of interest to the whole medical community to know what infant deaths are due to. In order to come to any conclusions as to cause and prevention, pathological studies must be available—both gross and microscopic. It cannot be strongly enough emphasized that in many cases cause of death cannot be known without autopsy. This community is fortunate in having well qualified pathologists who can perform autopsies and study microscopic sections. It is not sufficient to inspect gross tissues as is done in some localities, for accurate diagnoses.

In this issue is a case report which has some angles of interest to various branches of the profession. Your comments are requested in regard to the desirability of publishing such case reports.

Medical Legislation

Of 3,454 bills and joint resolutions introduced into the thirtieth and last session of the Territorial Legislature, only 192 were regarded by our Legislative Committee as having medical significance; only 306 were enacted or adopted into law.

The committee graded the 192 into five categories: +2 (active support), 32 items; +1 (passive approval), 53 items; 0 (neutral), 51 items; —1 (passive disapproval), 26 items; and —2 (active opposition), 32 items.

Duplication in House and Senate reduced the total number of items rated +2 or —2 from 64 to 48. Of these, only 15 became law in spite of our opposition, or failed despite our support. In just one instance (the "Eyeball Bill," which would have virtually taken the prescription of contact lenses out of the hands of ophthalmologists and given it to optometrists) was success achieved only by persuading the Governor to veto the measure. The other 33 items were acted on in accordance with our recommendations.

The Maluhia Conversion bill, which would have burdened Honolulu with a County General Hospital, was reported favorably out of the Oahu Select Committees of both the House and the Senate despite a deluge of convincing evidence presented against it by individual physicians, hospital administrators, nurses, educators, and others. Evidence offered in its behalf was repeatedly and thoroughly discredited. Yet we failed to block it at this stage, and its ultimate failure in the Ways and Means Committee of the Senate and the Finance Committee of the House cannot be credited to our efforts.

These two signs of our political weakness and ineptness far outweigh the otherwise highly creditable performance of our Legislative Committee, and point clearly to the necessity for the medical profession in Hawaii to step up the tempo of its political activity, in a variety of ways.

One important one is for individual doctors to donate to individual candidates' campaigns and to help campaign for them. Most legislators consider themselves obligated, in varying degrees, by accepting such support; and at the very least, they will be grateful enough to listen attentively when the occasion arises—which is all a man with a good product needs to ask. And we doctors *have* a good product; very rarely have we an "axe to grind."

Another vitally necessary step is for doctors to be willing to give up some time from their practice to attend committee hearings. There is no period in the life of a bill when it is more important to be on hand to bring your influence to bear, for or against it.

A third useful thing would be for doctors to become more active in precinct work — for the party of their choice, be it Republican or Democratic. Help get out votes; help find unregistered voters and get them to register; help find voters who failed to vote in the primary and remind them to vote in the general; and put in a word for your favorite candidate at the same time.

Our failure in those two major items in the last session is cause for alarm. If we don't wake up and work, we may find the optometrists arrogating all refraction work to themselves, and a County Hospital in operation on the hill, with no residency training programs in private hospitals and no more approved schools of nursing.

As a first step, we urge serious consideration of the employment, during legislative sessions, of a special assistant to the Chairman of the Legislative Committee of the Hawaii State Medical Association, who would devote full time to watching the introduction of medical legislation and its progress through committees, and to organizing the appearance of physicians at various hearings. The strongly liberal tinge of the present House of Representatives presents a challenge which the medical profession cannot afford to ignore.

This is What's New!

The most ominous omen in **systemic lupus erythematosus** is evidence of **renal involvement.** Patients who have polyserositis, mild carditis, and lupus encephalitis usually respond well to corticosteroid therapy and have a favorable prognosis. The prognosis was also much graver in men and in the young. (*New Eng. J. Med.* [June 11] 1959.)

* * *

Live polio vaccine was used during an epidemic of poliomyelitis in Singapore. The epidemic was due to Type I polio virus. Results: **179** cases of paralytic Type I polio in 300,000 nonvaccinated cases contrasted to **six** cases of paralytic Type I polio in 200,000 vaccinated children. How Type II vaccine protects against Type I virus, no one knows. (*Brit. Med. J.* [June 20] 1959.)

* * *

Radioactive rose bengal [rose bengal tagged with I^{131}] or **radioactive BSP** will probably replace the untagged dyes in diagnosis of **liver disease.** A small amount of the tagged dye is injected intravenously. The disappearance of the radioisotope from the blood is determined by external counting over the ear. Jaundice does not interfere with the test. The level of radiation is about the same as that for thyroid uptake studies. Consequently, repeated tests can be performed without hazard to the patient or interference with the test. (*J.A.M.A.* [July 4] 1959.)

* * *

An **oral contraceptive** containing a **progestin-estrogen** combination has been found to be as effective as any means used thus far. This preparation works by causing anovulatory menstrual cycles. In a combined series conducted in Puerto Rico and Haiti, a 96 per cent reduction in pregnancy resulted, and the pregnancies were directly related to the number of tablets missed. (*Science* [July 10] 1959.)

* * *

Fibrinolysin [detailed as Actase by Ortho] is an enzyme that **dissolves fibrin** but without significant effect on blood coagulation. Fifty to 100 thousand units of fibrinolysin, intravenously, will dissolve venous thromboses if used soon after the thrombotic episode. If organization and fibrosis of the clot occurs, the fibrinolysin is without benefit. One limiting factor is the cost, currently $56 per 50,000 units. (Ortho Pharmaceutical Corp., Raritan, N. J.)

At least **a third of myocardial infarcts are silent.** At the time of periodic cardiovascular examination at Framingham, it was determined that a significant number had typical electrocardiographic patterns of myocardial infarct without a clinical history of infarction. As might be expected, the silent infarcts were "milder" from all aspects, and were followed less frequently by angina than were other recognized infarcts. (*Ann. Int. Med.* [June] 1959.)

* * *

Medical care has now joined the **credit card** rage that has swept the Mainland and Hawaii. The Bank of America, joining forces with an insurance company and the Fresno County Medical Society, has issued credit cards for 100 days' hospitalization and complete medical and surgical services. (*Scope Weekly* [June 10] 1959.)

* * *

Five hundred delegates to the British Medical Association's meeting voted to **strike against the National Health Service** if the government rejects their demand for a **10 per cent increase** in pay. The average income of the British family physician, under the National Health Plan, is $6,793 a year. If the strike is carried through, some 40,000 physicians would be involved in the walkout. (*A.M.A. News* [July 27] 1959.)

* * *

Corticosteroids do **not** alter the course of **mumps orchitis** in El Paso, Texas, and presumably also do not alter the course of mumps orchitis in Hawaii. A double blind series of patients with mumps orchitis treated symptomatically, or with a placebo, or with prednisone revealed no difference in the course of the disease in the three groups. (*Am. J. Med. Sc.* [June] 1959.)

* * *

For a number of reasons, the **diastolic murmur** in acute rheumatic fever **may be missed.** This unheard murmur may erroneously suggest a recurrence of rheumatic fever if heard at some later date. Of patients referred to a rheumatic fever unit, about 10 per cent had the murmur missed by competent examiners at a teaching hospital, and about 40 per cent of patients referred from nonteaching hospitals had "unheard" murmurs. (*New Eng. J. Med.* [June 25] 1959.)

FRED I. GILBERT, JR., M.D.

Infant Death Case Study

This term female infant was born in a rural hospital, after 12 hours of labor, to a 33-year-old secundipara, whose previous pregnancy had resulted in a spontaneous abortion at three months' gestation (cause unknown). Prenatal care included two office visits during the first trimester, three the second, and six during the third. Her total weight gain during pregnancy was 36 pounds, most of it during the last three weeks. Because of her previous abortion, she was given cyclic estrogen-progesterone for three months preceding conception and Delalutin during the first four months of the pregnancy. Physical examinations and laboratory studies were normal throughout pregnancy. Pelvimetry disclosed an adequate pelvis.

Membranes ruptured spontaneously two hours before contractions began; there was, thereafter, virtually no flow of amniotic fluid. The mother was extremely restless and intolerant of pain. Analgesia and anesthesia included: Thorazine 25 mg nine hours before delivery; Demerol 75 mg eight hours before, and 50 mg five hours before; Nupercaine saddle block three hours before delivery, repeated two and one-quarter hours later (given early intentionally because of difficulty in restraining patient and reluctance to use general anesthesia or more analgesia). Pitocin, ½ ampule in 1000 cc of water, was given "for gentle stimulation during last three hours of second stage with continuous regulation by physician." Low forceps ("easy application") were employed for cephalic presentation, ROA of the infant. Fetal heart tones were last recorded and normal one hour before delivery.

The infant weighed 7 pounds 14 ounces. Respirations began four minutes after birth and steadily improved in rate from five per minute to 22 per minute. She received Nalline one minim intramuscularly twice and caffeine intramuscularly once. She received continuous oxygen and intermittent gentle manual stimulation to pectoral muscles. She urinated, defecated, and cried weakly. Two and one-half hours after birth she expired. Postmortem examination was limited to the head and findings were described as: "(1) Hemorrhage, subdural—clot covering about one-half of left parietal lobe—source not identified; (2) Massive cerebral edema of both hemisperes, with bulging bilaterally as dura was incised. No demonstrable injury to skull or scalp."

Discussion:

1. In view of the apparently normal progression and short duration of labor, the Committee questioned the advisability of Pitocin.
2. Although subdural hemorrhage occasionally occurs with spontaneous delivery, the the Committee felt that the forceps procedure may have been responsible for the hemorrhage in this infant despite the "easy application." The amount of force applied to an infant's head during forceps procedures may be difficult to evaluate subjectively.
3. Saddle block, while a proper analgesic, can occasionally be given too early in labor (as in this case) so that what might have been a spontaneous delivery could turn out to require mid- or even high-forceps extraction with resultant increased likelihood of trauma to the infant's head.
4. The absence of fetal heart determinations during the hour preceding delivery is lamentable since careful and frequent observations of fetal heart tones during this period may give advance warning of fetal distress (in this instance it appears to have had no bearing on the infant death).

One factor which the Committee found difficult to evaluate in this instance and may on occasion lead a physician reluctantly into an overabundance or ill-timed use of medication and instrumentation, is the problem of the "difficult patient" who tolerates the pain of labor poorly.

Conclusion: This infant death was classified as obstetrical and preventable.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

Why HMSA instead of Insurance for my patients?

The young physician just entering private practice can well ask this question . . . and some of the established practitioners as well. Here, then, are some answers to this question.

HMSA is *different* from insurance, because:

. . . HMSA is non-profit. Its main purpose is to help pay for and otherwise facilitate medical service for its members. All of HMSA's income belongs to its members, and is available to them to pay for their doctors' services.

. . . HMSA, wherever possible, compensates the participating physician directly, and sufficiently so he will not have to look to the patient for supplementary payments. Therefore, HMSA attempts, wherever possible, to provide benefits in terms of *service,* rather than of dollars.

. . . the policies and practices of HMSA have been and are developed with the sponsorship and assistance of the medical profession.

. . . HMSA has a social purpose. It seeks to do what the profession itself traditionally has always sought to do—meet the needs of the *entire* community.

. . . HMSA preserves the factors of free choice, fee-for-service, and the private patient-physician relationship—factors that are basic to good medical practice.

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In Memoriam -- Doctors of Hawaii -- XXII

This is the twenty-second installment of In Memoriam—Doctors of Hawaii.

Perley Johnson Aiken

Perley Johnson Aiken was born at McConnelsville, Tennessee, September 5, 1841, the son of the Rev. William Aiken, a Presbyterian minister of Knoxville, Tennessee.



DR. AIKEN

He was educated at Washington College, Pennsylvania, but left before graduation to join the Anderson Cavalry of the Union Army. Invalided home, he recovered his health and reenlisted in the Army Signal Corps serving as sergeant in charge of a station at Georgetown Heights, Pennsylvania, until the end of the war. With his military service at an end, he entered Jefferson Medical College at Philadelphia from which he graduated in 1867.

On October 1, 1867, Dr. Aiken married Miss Julia Orilla Smythe of Newark, Ohio. Six children were born to the doctor and his wife: Albert C., Perley B., Worth O., Lillian A. (Mrs. Alexander Ball), George S., and Irene (Mrs. Starrett).

Dr. Aiken began his practice in the town of Cleveland, Tennessee. From there he moved to Virginia City, Nevada, in 1874, and in 1879 to Woodland, California. Following which he served six years as Medical Director of the Soldiers' Home at Yountville, California.

Learning that Paia, Maui, needed a doctor, Dr. Aiken arrived in 1894 to serve as physicion for Paia and Hamakuapoko plantations as well as government physician for that part of Maui. Dr. Herbert, physician for Wailuku and West Maui, and Dr. Aiken were the only doctors on the Island, and they had to travel long distances with horse and buggy. That same year Dr. Herbert moved to Honolulu and Dr. Armitage took his place at Wailuku.

In those days the roads were bad, very dusty in dry weather, and deep in mud in rainy times. There were deep ruts caused by the heavy ox carts, which were the only means of transportation for freight, lumber, etc.

On one particular occasion, Dr. Aiken was called in the night to see a very ill woman in Kula. He drove to the end of the road where a saddled horse was waiting for him, and, leaving his buggy there, he rode through a terrific Kona rain to her home. As the woman was too sick to leave, the doctor had to stay in his wet clothes all night. This occurred early in a very stormy winter with much sickness. He contracted a severe cold and, although tired and ill, there were too many demands for his services for him to be able to stay at home. This was the beginning of the illness which caused him to retire in 1898 and which ultimately caused his death.

Dr. Aiken died at Makawao, Maui, on October 26, 1905, at the age of 64.

He was a commander of the Knights Templars, 32nd degree, of Woodland, California.

Nicholas Russel

Nicholas Russel was born in Russia in the year 1850 and was, by birth, a nobleman.

He was a graduate of the University of Kiev.

Incurring the wrath of the Russian authorities by his seditious utterances at a student meeting, he was ordered to be arrested. However, with the help of his 16-year-old sister, he escaped from Kiev disguised as a Mohammedan and fled to Romania. From there he made his way to Bulgaria and then to Greece where he married. Another version of the story has it that both Dr. Russel and his wife were Imperial Court physicians who fled from Russia during a revolutionary upheaval. In any event, married or single, the doctor departed hastily, and certainly he was *persona non grata* at the Russian court.

Dr. and Mrs. Russel eventually got to Paris where the doctor practiced for several years before coming to San Francisco. While in San Francisco, Dr. Russel became involved in an argument between two factions of the local Greco-Russian church. Early in 1890 he brought charges against Bishop Vladimir of the church. Both the doctor and his wife withdrew from the church, following which Dr. Russel was excommunicated. Both factions were so bitterly opposed to each other that Bishop Vladimir was arrested and libel suits ensued. The argument was finally terminated from St. Petersburg by the recall of the Bishop. He was replaced by Archimandrite Innocente whose appointment was regarded as a great victory for the doctor.

During this period, Dr. Russel wrote continuously on reform matters, and this literature was smuggled into Russia and secretly circulated among the peasants. He constantly contributed money to Russians who sought his help, and at times his generosity left him penniless.

The doctor came to the Islands and was a Government Physician at Waianae, Oahu, from May 20, 1892, to March 31, 1894. The 1896-1897 Hawaiian Directory lists him as practicing in Honolulu with offices in the Masonic Temple on Alakea Street. In 1898 he is listed as physician, surgeon, and coffee planter in Hilo, Hawaii. Some time in 1900 he moved to Olaa where he continued to practice and raised coffee.

In 1896 Dr. Russel published a book *How to Live on the Hawaiian Islands,* which dealt with individual hygiene. It enjoyed a great popularity.

Dr. Russel was elected a member of the first Territorial Senate in 1901. He was chosen President, but since as President he could take no part in the debates, he resigned that office to become a part of the legislative body.

Becoming interested in the cultivation of sugar cane as well as coffee, the doctor took a trip to the Far East in 1903 to try to raise money for the promotion of a large sugar plantation in Olaa. In 1905 he went to Japan in an attempt to incite Russian prisoners of the Russo-Japanese war to revolt against the Czar.

About 1908 or 1909 Dr. Russel left the Islands. His last address listed with the American Medical Association was Tientsin, China, and it is presumed he died there.

Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING

July 23, 1959, at 6:30 P.M.
Oahu Country Club, Honolulu

PRESENT:

Dr. Toru Nishigaya presiding; Drs. Yap, Giles, Bergin, Allison, Spencer, Goodhue, and Burden, plus guests Dr. Thomas H. Richert and Mr. R. M. Kennedy.

MINUTES

The minutes of the March 18, 1959, meeting were approved as published.

WELCOMING ADDRESS

The president, Dr. Toru Nishigaya, welcomed the new members of the Council, Drs. Allison and Goodhue, and thanked the members for taking the time to come to the meeting. He asked for free discussion on all matters and expressed the hope that the members would give their ideas on the matters that were to come up. He said he would especially like neighbor island members to ask questions in order that they could take back to their component societies information on what is going on in Honolulu.

MEDICARE CONTRACT

The present contract will expire August 31, 1959. It was explained that the Federal Medical Services Committee is about to open negotiations by letter with the Office for Dependents' Medical Care in an effort to adjust fees to conform to our relative value schedule using current conversion factors. Dr. Burden asked that if any meetings were held on this, neighbor island representatives be invited to attend.

ACTION:

The President was authorized to sign the contract when it was ready.

FEDERAL MEDICAL CARE OF VETERANS

Dr. Nishigaya reviewed a request that we join the Medical and Chirurgical Faculty of the State of Maryland in requesting the AMA to appeal to Congress to schedule a hearing on the matter of limiting federal medical care of all veterans to service-connected disabilities. The importance of advising the general public of the cost of this program and of getting the cooperation of lay groups to press for reforms in this program, to correct the false impression that the doctors were fighting it for selfish reasons, was emphasized.

ACTION:

The President was empowered to write a letter to the AMA and to Maryland advising that the HMA would like to ask for a congressional hearing.

GROUP LIFE INSURANCE

Mr. Kennedy explained that the HCMS enrollment period is about to begin through Canada Life and that the rates being offered were below the GP policy rates. The policy is based on a $20,000 maximum and begins to decrease at age 50 with a constant premium. At the age of 70 the benefits are $500. The brochures are now being printed and should be out the first of the month. HCMS asked Canada Life if they could take in the other islands and they were advised that this can be done in one of two ways: either each county can stand on its own and get 75%, or all the counties can be combined and the total will have to represent 75% of their combined total membership. Honolulu County will receive a "retention figure", which will amount to possibly $25,000.00. HCMS has made no decision on the disposition of this money. It could be put in a trust fund and saved for a year when there is a bad loss experience. If there is good experience, the doctors' premiums could be waived for a year. Some counties have used this as a building fund. The premium will be paid semi-annually and will be due the same time each year. New members will be able to have the premium prorated. If the neighbor island societies come in, it will be handled by Honolulu county. A big advantage in this policy is that the premium is waived for life if the subscriber doctor becomes permanently disabled. He said the brochures could be sent out to the other islands at the same time they are sent to Honolulu members but they cannot be included in the HCMS's 75%. Mr. Kennedy offered to visit the other counties, or have Mr. Fifield represent him, to explain the policy. The neighbor island doctors expressed the belief that it would be preferable to make each county responsible for enrolling 75% of its members. Dr. Bergin suggested that it would be better to bring the brochures to the meetings rather than mail them in advance but that one copy should be mailed to each county secretary.

GROUP HEATH AND ACCIDENT COVERAGE

Mr. Kennedy said that when the group health and accident proposal was referred to the President of the HMA he was not interested and that it cannot be opened up to neighbor island doctors now. The HCMS plan cannot even be bought today on the open market and the experience on it has not been good for the carrier.

OVERHEAD INSURANCE

Mr. Kennedy explained that the HCMS was looking into this through their public service committee but it was the consensus of this group that action should be deferred until the group life coverage is established. Dr. Yap mentioned that the Academy of General Practice had a similar plan.

INVESTMENT PROGRAM

Mr. Kennedy said that the Securities Exchange Commission had ruled that the reduction in loading charges was no longer possible to realize. This was the big advantage of the programs being run through the Bureau; now that the doctors are going to have to pay the regular commissions, there is no advantage to the plan. The ruling has been appealed. Los Angeles County is especially anxious to have it voided.

MICHIGAN ASSOCIATION OF THE PROFESSIONS

This new organizational idea was discussed. Dr. Richert said that in a community as small as this, there could be too many societies and that he thought it might be well to get behind an established society such

(Continued on page 62)

Book Reviews

★ Spinal Anesthesia

By John B. Dillon, M.D., 61 pp., $3.00, Charles C. Thomas, 1958.

This 61-page monograph clearly and concisely covers spinal anesthesia. The author discusses in detail its advantages and disadvantages, indications and contraindications. There are 23 pages devoted to the technique. It should be very helpful to any physician who has occasion to administer or recommend spinal anesthesia.

HELEN WALLACE, M.D.

Peripheral Circulation in Health and Disease

By W. Redisch and F. Tanco, 160 pp., $7.75, Grune & Stratton Co., 1957.

The reviewer regretfully has to state that this book adds little to the field of cardiology. The more than four hundred illustrations are nicely shown, but the text is somewhat disjointed and difficult to correlate with the illustrations. This reviewer always hesitates to criticize a book and the fact that two years have gone by since I was asked to review it perhaps indicates the impression the book made.

ALFRED S. HARTWELL, M.D.

★ Orthopedic Diseases

By Ernest Aegerter, M.D. and John A. Kirkpatrick, Jr., M.D., 602 pp., $12.50, W. B. Saunders Company, 1958.

This book on basic orthopedic subjects is written by a radiologist and a pathologist and presents the basic science aspect of bone disease, delightfully simply and concisely. The correlation between pathology, x-ray, and clinical findings is presented in a manner which can be easily understood by residents or by busy practitioners. The book should be of decided value as an addition to the orthopedist's library or the hospital training program in orthopedics.

IVAR J. LARSEN, M.D.

The Birth of Normal Babies

By Lyon P. Strean, Ph.D., D.D.S., F.A.P.H.A., 194 pp., $3.95, Twayne Publishers, 1958.

This book is written in lay terms and is intended primarily for prospective mothers and other members of the family so that they may be guided in their behavior towards the pregnant woman.

It consists, in essence, of a series of 60 case histories, based on the premise that stress of some sort in the early stages of embryonic formation is more often responsible for various anomalies of the product of pregnancy, than is faulty heredity. The author is a full-time research scientist, trained in dentistry, who became interested in the whole broad subject of congenital anomalies because of the large number of cleft palate cases referred to him for corrective procedures. It is interesting to note that he is the brother of an obstetrician of wide experience.

Dr. Strean feels that an extensive educational campaign aimed at elimination of dietary defects, severe emotional stress, virus infections, etc., will reduce the incidence of abortions, stillbirths, and congenital anomalies. While interesting to those of the medical profession, it is not a book that will carry any great appeal to physicians except to emphasize educational angles to groups of pregnant women and their families.

H. E. BOWLES, M.D.

★ means highly recommended.

Viral Encephalitis

By Wm. G. Fields and Russell P. Blattner, $7.00, 225 pp. Chas. C. Thomas Co., 1959.

This compilation of the presentations at the Fifth Annual Houston Neurological Society meeting, March, 1957, is of particular interest to neuropathologists and those interested in arthropod-borne viral encephalitides (three-fourths of the symposium is devoted to these encephalitides and the neuropathological results of viral infections—exceptionally well done).

Western equine encephalitis (WEE), Eastern equine encephalitis (EEE), Venezuelan equine encephalitis (VEE), and Japanese B encephalitis are as yet unknown in the Islands although the insect vectors, Aedes and Culex, and principal animal reservoir, wild birds, are abundantly evident. Recent cases of encephalitis have strongly suggested a Japanese B infection. Importation of Japanese pheasants known to be potential reservoirs of Japanese B encephalitis strengthens this possibility. Virus studies are currently under way; should these cases prove to be Japanese B or related arthropod-borne viral encephalitides, this symposium becomes a virtual "must" for all practitioners.

Sections on control and laboratory diagnosis of neurotropic viruses are now incomplete in the light of the rapid advances of the past two years.

These shortcomings notwithstanding, this book is extremely interesting reading for those with leisure time and the interest therein, and a worthwhile addition to the reference library.

WILLIAM F. MOORE, JR., M.D.

★ Pathophysiology in Surgery

By James D. Hardy, M.S. (Chem.), M.D., F.A.C.S., 704 pp. illus., $19.00, The Williams & Wilkins Company, 1958

This volume fills a vital need. It is a superior work, designed to give the beginner as well as the experienced surgeon valuable information. It is divided basically into two parts. The first deals with such basic problems as the physiology of injury, body fluids, surgical nutrition, wound healing and homotransplantation, thermal burns, cancer, radiation and radioactive isotopes, surgical enzymology, and the biology of aging. This section serves as an introduction to the second, which is more specific. It deals with the surgical diseases of the various organ systems such as the liver, biliary tract, pancreas, blood, spleen, alimentary tract, circulatory system, lungs, nervous system, endocrine system, and genito-urinary system. Also included are chapters on anesthesia as it relates to the surgeons and the special problems of pediatric and urological interests.

The reader will recognize immediately that *Pathophysiology In Surgery* is a major undertaking of su-

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Notes and News

Dr. Masato Hasegawa, our News Editor, is in Europe, attending a medical meeting. There is no Assistant News Editor, and the other members of the editorial staff have other fish to fry.

If the omission of this section of the Journal grieves you, dear reader, we would like to know it. If we don't hear from you, we will assume you don't miss it, and we will save a great deal of trouble and a little money by leaving it out in future issues and merely printing such announcements and news items as may be contributed from time to time.

The National Foundation's Patient Aid Policies

Hawaii Chapters of The National Foundation have expanded their patient aid programs to include rheumatoid arthritis and birth defects (hydrocephalus, encephalocele, and spina bifida) in addition to poliomyelitis.

The National Foundation has not changed its concept on serving the patient with a disability, but it has been necessary to make certain policy changes nationally to utilize available resources where they can be of most service to all persons covered under the expanded program. The policy changes emphasize patient care in the early phases of disease. The objective is recovery with minimum disability and maximum independence.

The following is a resumé of general Chapter expenditures under the new patient aid policies:

	Poliomyelitis	Rheumatoid Arthritis	Birth Defects
Eligibility	All paralytic patients for 2 years from date of onset; thereafter, children under 19 and adults with severe involvement.	Children under 19.	Children under 19.
Hospitalization (but not to extend insurance coverage)	1st year—180 days; thereafter, 150 days in any 12 month period.	1st year—60 days; thereafter, 30 days in any 12 month period.	1st year—90 days; thereafter, 60 days in any 12 month period.
Outpatient	Yes	Yes	Yes.
Physical Therapy	Yes	Yes	Yes.
Braces, Appliances	Yes, including replacement of outgrown braces, but not repair or replacement of damaged or worn braces and appliances.		
Other	Special duty nursing up to 14 days for critically ill patient. Home attendant or nursing home care up to $200 per month for 2 years after onset.	Diagnostic services; i.e., x-rays, L-E tests, urinalysis, synovial fluid analyses, etc. Approved drugs.	Diagnostic services; i.e., x-rays, routine blood counts, urine and blood cultures, urinalysis, etc. Psychological evaluation. Approved drugs.
Prohibited Chapter Expenses	Medical and surgical fees, treatment expenses for unrelated concurrent disease, travel or living expenses for change of climate, summer camps, etc.		

It is to be recognized that the transition into the expanded program will not be accomplished overnight. The change to the new policies for poliomyelitis patients currently on Foundation Chapters' rolls is being made only after the families have been advised of the new policies and the attending physicians so informed.

For further information, physicians may contact Mrs. Carolyn Patterson, Hawaii State Representative of The National Foundation, 1018 Lunalilo Street, Honolulu 14, telephone 61-045.

WILLIAM FRANCIS LESLIE, M.D.
1903 - 1959

Dr. William Francis Leslie died on Saturday, July 4, 1959, as the result of hypertensive and arteriosclerotic heart disease. The following is a resume of some of Dr. Leslie's life activities:

He was born on May 12, 1903, in Mishawaka, Indiana; attended public schools in Mishawaka; M.D. degree University of Indiana, 1928. Internship: Kingston Avenue Hospital, Brooklyn, New York (July 1, 1928, to February 1, 1929); The Queen's Hospital, Honolulu (April 1, 1929, to October 31, 1930); joined staff, Leahi Hospital, Honolulu (November 1, 1930, to September, 1942); Medical Director of Puumaile Hospital in Hilo (1942 to 1946); Superintendent and Medical Director of combined Hilo Memorial and Puumaile Hospitals (1946-1959); and in recent years Director of Puumaile Hospital, Hilo.

Membership: Territorial Hospital Association (past president); Hawaii County Medical Association (past president); Fellow, American College of Chest Physicians (governor for Hawaii); Director, Hilo Community Theater; member, Benevolent and Protective Order of Elks, Hilo chapter.

The above record indicates a man active and successful both in his medical life and in the community. Dr. Leslie will be sorely missed; he was a positive character. He had an extremely persuasive way of presenting whatever causes he was sponsoring. Bill never liked placid surroundings and seemed to enjoy a contest. He invariably defended the "under-dog." Those who knew Bill well understood that he was a sensitive person with a strong sense of justice and idealism. He had a great sense of fun and jestful life. These endeared him to his close friends and throughout his years in hospital work, he was dearly beloved by his patients and extremely well liked by the hospital staff and personnel.

Some of his hobbies included an unusual skill in archery; he was a collector of recorders and fine old European music boxes; and his interest and participation in amateur theatricals in Hilo in later years were a source of satisfaction to him. He had more than average ability as an amateur photographer and had a well-equipped home workshop.

It will be difficult to replace such a positive personality as Dr. Leslie and he will be forever missed by his friends and associates. He is survived by his wife, Rose Yee Leslie, and their daughter Patricia (Mrs. John Roberts).

ALFRED S. HARTWELL, M.D.

GEORGE WILLIAM BACHMANN, JR., M.D.
1914-1959

George William Bachmann, Jr., "Bachy" to his friends and patients, was born in Rochester, New York, in 1914, and moved to Santa Monica, California, in 1919. He went to Army and Navy Military Academy in San Diego, then Menlo Junior College; he graduated from Stanford University in 1936, and from the University of Southern California Medical School in 1941. During an internship and residency at Los Angeles County Hospital, he started to specialize in anesthesia. He studied under Dr. Arthur E. Guedel, and became his close friend and admirer. Dr. Guedel subsequently became godfather to George William Bachmann III.

George went with the 73rd Evacuation Hospital Unit from Los Angeles, Army Medical Corps, as Chief Anesthetist, in February, 1942, to the China-Burma-India theater. He served with Dr. Gordon Seagrave, was medical Liaison Officer with the Chinese Army at the front (walked in with General Joseph Stillwell in 1943), and spent several months with Merrill's Marauders. He was promoted to Captain and was with the 14th Evacuation Hospital Unit, as chief of anesthesiology, when it received the Presidential Unit Citation.

He returned to the U. S. after 28 months of overseas duty, married Suzanne Sharp in 1945, and entered the private practice of anesthesia in 1946 in Pasadena, California. He became a diplomate of the American Board of Anesthesiology in 1947. He was offered a Fulbright Award for the teaching of anesthesia in India in 1953, an honor which he was unable to accept. He practiced anesthesia in the Los Angeles–Pasadena, area from 1946 to 1956, at the end of which time he moved to Hawaii and served as head of the Department of Anesthesia at Kauikeolani Children's Hospital for three years, until his death on July 3, 1959. He is interred in the Punchbowl Military Cemetery of the Pacific.

Dr. Bachmann was a member of Sigma Alpha Epsilon and Phi Rho Sigma fraternities, the Honolulu County Medical Society, the Hawaii Medical Association, and the American Medical Association; a Fellow of the American College of Anesthetists; and a member of the American Society of Anesthetists. He was vice-president of the California Society of Anesthesiologists in 1952, and a member of the House of Delegates of the American Society of Anesthetists, in 1953.

His passing leaves his wife, Suzanne Bachmann; his daughters, Karen and Lynn, aged 12 years and 10 years, respectively; and his son, Bill, aged 8.

MRS. GEORGE W. BACHMANN, JR.

County Society Reports

Kauai

The regular monthly meeting was held on June 2, 1959, at 7:35 P.M. in the library of Wilcox Memorial Hospital.

After the reading of some miscellaneous correspondence, Dr. Fujii reported on the HMSA Board meeting. This led to a lengthy discussion of the changing picture of medical economics here, where the standard $3 fee for an office visit has remained fixed for years in the face of rising overhead costs.

Dr. Worth asked the members for their opinion about using the visiting specialists at Wilcox Hospital to give consultation on indigent cases. Heretofore the only way to get consultation for these cases has been to transfer them to The Queen's Hospital as staff cases, at great expense to our Medical Care funds. After considerable discussion, Dr. Worth was asked to write a letter from the County Medical Advisory Committee to the Kauai County Board of Supervisors asking them to authorize the use of our consultants locally as a cost-saving measure, and asking the Board to set up a special appropriation from their general fund to pay for the consultants' fees; since the Medical Care fund cannot be used for this purpose.

After a brief discussion of the relation of Public Health clinics to the private practice of medicine, the meeting was ajourned at 8:50.

ROBERT M. WORTH, M.D.
Secretary

Hawaii

The monthly meeting of the Hawaii County Medical Society was held June 25, 1959 at the Hilo Hotel.

A small but interested audience heard Mr. Robert Midkiff, a vice-president of the Hawaiian Trust Company, Ltd., discuss pertinent aspects of the Keogh Bill, of Social Security, and then summarize present investment opportunities in the Islands.

* * *

The July 18 meeting of the Society was held at the Naniloa Hotel. Guest speaker was Doctor C. Henry Kempe, Professor of Pediatrics of the University of Colorado and visiting professor at Children's Hospital. Guests were Mr. Thomas Vance, recently appointed administrator at Hilo Memorial and Puumaile Hospitals; Dr. Schmidt, of KMC; Dr. Aniol, intern at Hilo Memorial Hospital; Miss Miriam Kemmerer, Superintendent of Nursing at Hilo Memorial Hospital; and four members of the pediatrics nursing staff.

Dr. Steuermann read a letter from the Hawaii Heart Association which expressed opposition to the methods employed by United Fund and similar federated fund drives. The letter further stated that the Honolulu County Medical Society had passed a resolution supporting independent fund raising drives and opposing federated fund drives. Dr. Miyamoto moved that the letter be placed on file. Dr. Okumoto seconded the motion, and the Society approved it.

Dr. Harold Lewis was elected Secretary of the Society to fill the unexpired term of Dr. Ruth Oda, who resigned as Secretary in June when she went to the Mainland for a year of postgraduate study.

Dr. Kempe gave an informal, interesting and highly stimulating talk on latest advances in virology and on the current status of various antibiotics. Dr. Kempe's forthright remarks concerning abuses of antibiotics were a pleasant—if brief—return to Academe.

HAROLD LEWIS, M.D.
Secretary

Maui

The Maui County Medical Society meeting was called to order at 8:00 P.M. by the President, Dr. L. T. Kashiwa, on Thursday, March 12, 1959, at the Central Maui Memorial Hospital.

Guests present were: Doctors David Kliewer, Henry J. Tumen, William N. Bergin (President of the Hawaii Medical Association) and Dr. Bainbridge from Vancouver.

Dr. Tumen gave a very enlightening talk on "The Metabolism of Bilirubin; The Current Status of Liver Function Tests and Their Clinical Application."

President of the Hawaii Medical Association, Dr. Bergin gave his presidential talk.

Delegates to the Hawaii Medical Association were appointed as follows: Doctors Fleming and Iaconetti.

A. Y. WONG, M.D.
Secretary

Honolulu

Dr. T. Richert presided at the January 6 meeting and approximately 75 members and guests were present.

An enlightening session of questions and answers conducted by a panel of representatives from HMSA was held. Mr. J. R. Veltmann, Executive Vice President; Mr. Albert Yuen, Asst. Secretary; Mr. Warren Gunderson, Asst. Treasurer and Dr. Robert Faus, Medical Director; were present to answer specific questions concerning HMSA which had been submitted in writing by members of the Society prior to the meeting.

For the benefit of the new members of the Society, Mr. Yuen gave a brief history behind the Association—Mr. Veltmann explained by the use of charts, the operating bodies of HMSA— Dr. Faus spoke briefly about his work as liaison officer between the medical profession and HMSA and Mr. Gunderson concluded by presenting some of the highlights of things of interest to the members in the past and which would be of even greater interest to the members in the future.

Drs. Teodora Fidelina-Avecilla, Marcelino Avecilla and George H. Stevenson were welcomed into the Society as new members.

Dr. John C. Milnor was presented with a plaque by Dr. Varian Sloan for his outstanding contribution in the Operation Hypo Program. Dr. Sloan stated that Dr. Milnor had attended twenty-five group polio clinics and given the largest number of polio vaccinations during this period.

Upon recommendation of the Board of Governors, it was moved, seconded and passed that Dr. Fred F. Alsup be made an honorary member of the Honolulu County Medical Society. The reason for the Board's recommendation was that Dr. Alsup who was a life member

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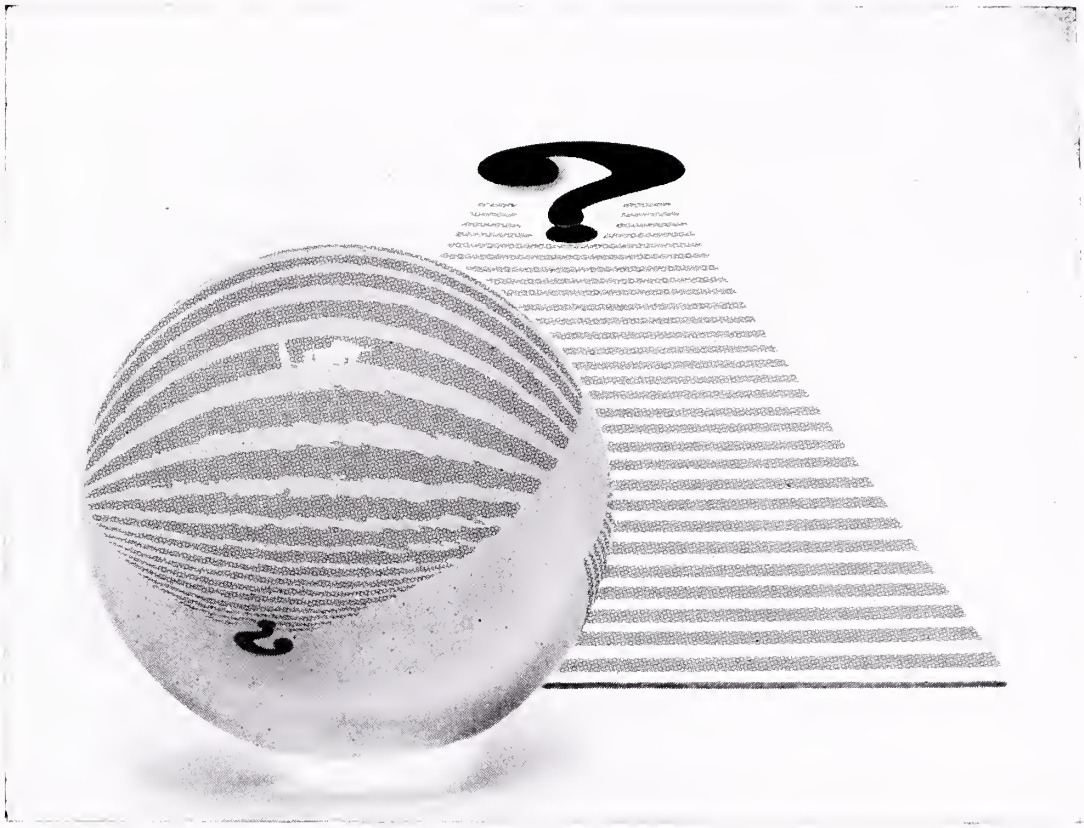
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Mysteclin-V Suspension (per 5 cc.)	125	125,000
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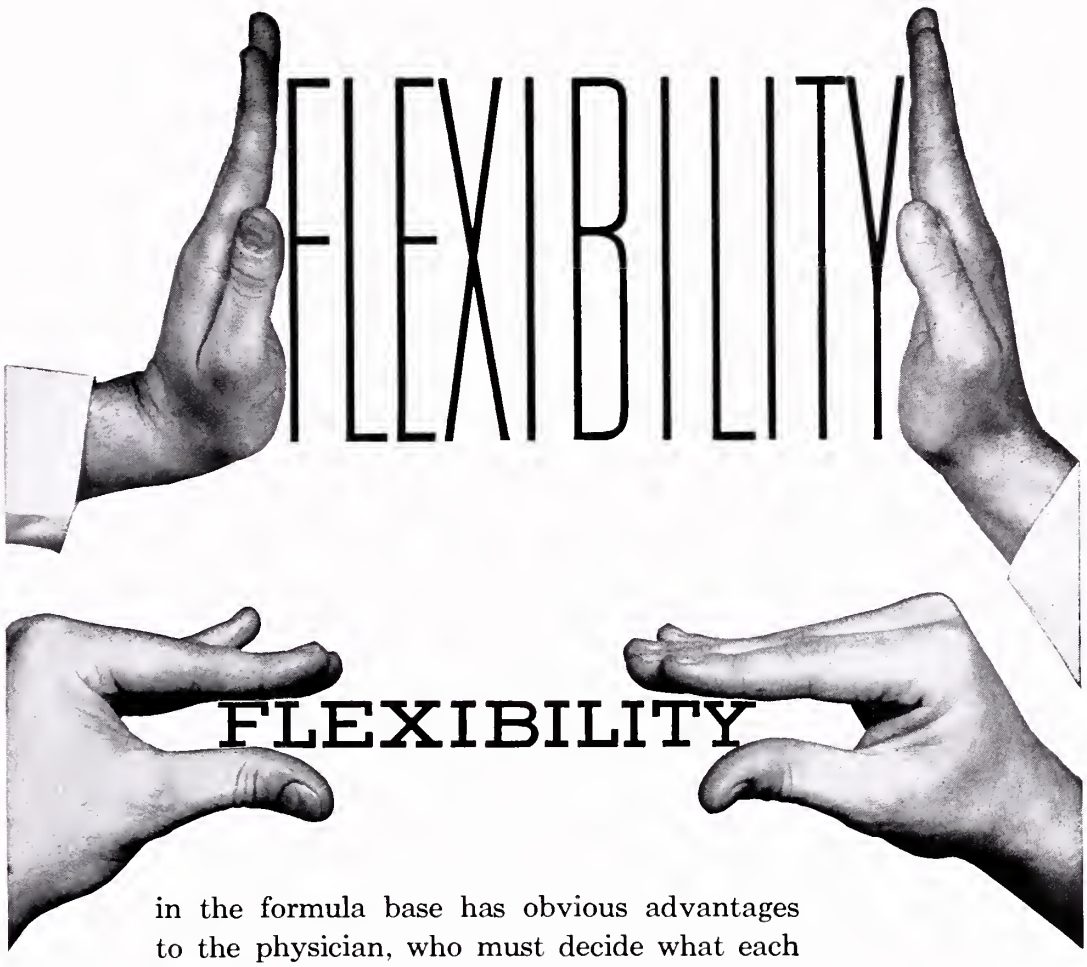
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in the formula base has obvious advantages to the physician, who must decide what each infant needs, and when changes are indicated. An evaporated milk formula is a prescription formula, permitting the physician to adjust

... the type and amount of carbohydrate

... the degree of dilution to required strength

Evaporated milk is the formula base proved successful by clinical experience . . . for 50 million babies.



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Higher protein level recommended when cow's milk is fed to babies

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wherever there is inflammation, swelling, pain

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Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery. By activating fibrinolytic factors VARIDASE shortens the *undesirable phase,* limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection ...new simple buccal route

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva. Dosage: One tablet four times daily usually for five days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid. Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase. Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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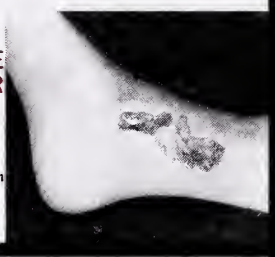




FORCE INJURY

severe bruises
. . . swelling
. . . cleared
by fifth day[2]





VARICOSE ULCER

15 years duration
. . . resolved with
VARIDASE[1]

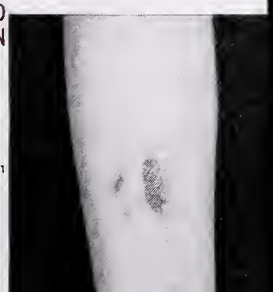




INFLAMMATORY DERMATOSIS

rapidly spreading
rhus dermatitis
healed within
a week[1]





INFECTED LACERATION

narked reversal
in 3 days . . .
returned
to school . . .
osure advanced[1]





THROMBOPHLEBITIS

back on his feet
in a week after
recurrent episode[1]





REFRACTORY CELLULITIS

normal routine
resumed after 4 days
of VARIDASE[1]

HAWAII MEDICAL ASSOCIATION

(Continued from page 52)

as the Hawaiian Academy of Science. Dr. Allison said he was a member of the Academy of Science and that there were no lawyers or architects in this group. The advantage of such an organization would be the furthering of special interests such as the veterans program. Dr. Bergin thought it might be well to wait to see how things work out in Michigan.

ACTION:

It was voted that the HMA take steps toward establishing an Association of Professions similar to that in Michigan. The motion carried after it was modified to include the provision that an appropriate committee investigate the possibility of establishing such an organization.

PROPOSED MEDICAL-LEGAL MEETING

Dr. Bergin said Mr. Belli would be delighted to give a major, provocative talk to the Association, and that some of the insurance carriers should be interested. The liaison pretrial meetings established by New York to try to avert malpractice suits were discussed. Dr. Spencer said the publicity should be considered.

ACTION:

It was voted to inform the Honolulu County Medical-Legal Committee that this man would be coming through Honolulu and ask them to report back to the HMA.

FINANCES

Dr. Nishigaya apologized to the Council for having gone over their heads in waiving the annual meeting registration fee for Dr. Dunn in order to avert any bad feelings between the Board of Health and the HMA. The matter of Dr. Mayer's dues' also having been waived was discussed as well as the policy of waiving dues of mainland doctors who had asked to speak on our program. No definite policy was set.

ACTION:

It was voted that we approve the waiver of these dues.

The Council questioned the necessity of waiving the HMA dues of members who had already been processed by the county involved. It was explained that the auditor had requested that this information be incorporated into the minutes in order that our books would be properly audited. The matter of the JOURNAL subscription was questioned.

ACTION:

It was voted that we automatically waive the dues of members after similar action by a county society.

Dr. Giles presented an interim treasurer's report which gave the Association's financial picture for the first six months of this year.

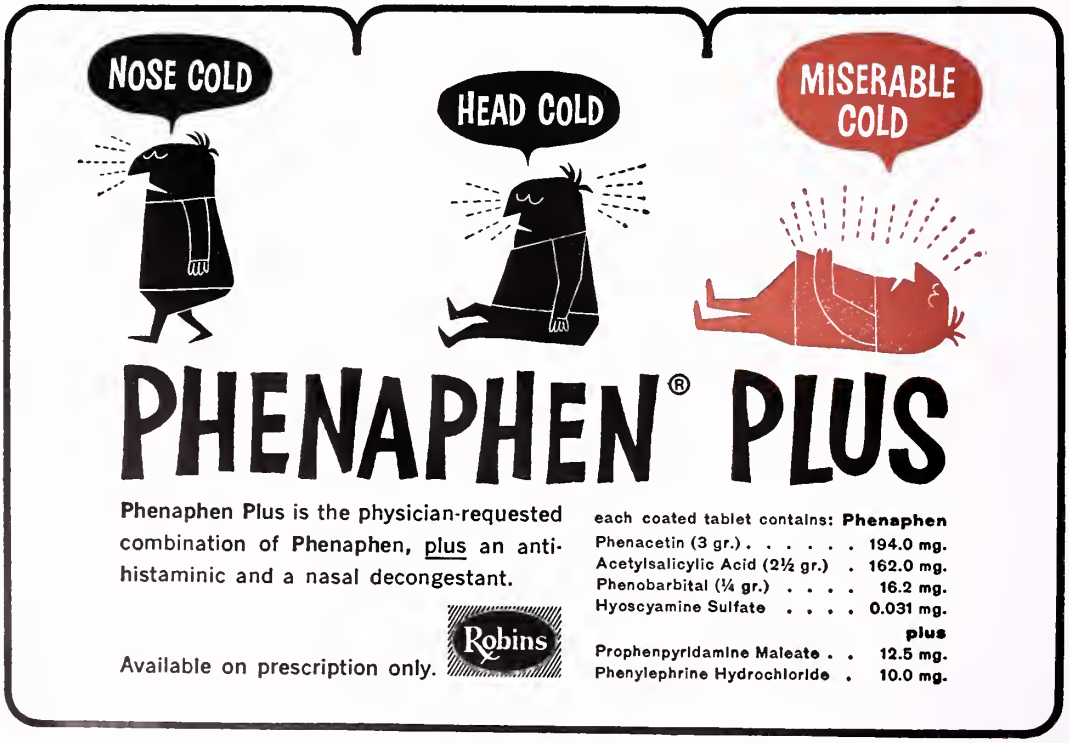
ACTION:

It was accepted.

FISCAL YEAR

The following letter signed by Frank R. Hough and dated April 6, 1959, was read:

> Pursuant to the action taken by the Hawaii Medical Association with respect to the adoption of a fiscal year ending December 31, I took the liberty of filing a formal request for approval of the change by the Treasurer of the Territory of Hawaii. This was necessary because the Hawaii Medical Association is a Territorial corporation.
>
> The change was approved by the Treasurer on March 31, 1959, and I am enclosing herewith for your records the official letter of approval signed by Mr. Saffery of the Treasurer's office. This is an important document and I suggest that it be included in the Association's official minute book.



TRANSMITTAL OF HCMS COMMITTEE MEETING MINUTES TO NEIGHBOR ISLAND SOCIETIES

A reply from Honolulu in answer to our request for transmittal of minutes to the neighbor islands, stated that their Board of Governors had approved of this arrangement but inasmuch as all minutes do not pertain to the Territory in general, specific request should be made as to the information desired. Dr. Nishigaya said he felt there had been some misunderstanding. What was meant was that if someone from the HMA could go over the minutes of the meetings and pick up relevant information, that information could be forwarded to the neighbor island societies. Dr. Richert said that the Board of Governors felt that the HMA wanted to take over the minutes of everything and that often the minutes of the committee meetings would be misleading if they were published before the Board of Governors acted upon them. Also there were many committees, such as those that dealt with censure of the county members, which would be of no interest to members of other county societies. Dr. Nishigaya felt that we had accomplished our purpose in that the Board of Governors o.k.'d the actions taken by the committees.

ROSTER

Dr. Goodhue said he had attended the meeting of the Board of Medical Examiners when they considered the matter of publishing a roster. They felt they had no access to the files. Mr. Kennedy related the experience of the collectors and wondered if there were anything in the law that said that a roster had to be published. It was suggested that the board of Medical Examiners should be requested at least to publish the names of the new members. Dr. Allison felt that it would be desirable to have such a roster. Dr. Nishigaya said the HSMA had offered to publish one as a stop gap if we wanted them to, but it would not contain photographs. Dr. Allison felt that photographs were important. The matter of the new ruling which applies to special funds was discussed. Dr. Nishigaya asked Dr. Goodhue if the Board might reconsider its decision and was told that there might possibly be a new Board appointed by the Governor and he didn't know whether or not he would be going back but that if he would certainly bring it up for discussion.

ACTION:

It was voted that we send the request back to the Board of Medical Examiners.

EMERGENCY MEDICAL SERVICE COMMITTEE

A letter from the Emergency Medical Service Committee was reviewed and it was explained that the problem of communications was a complex one and that actually the ideas of the committee were rather nebulous at this time. Since the latter was for information only, no action was taken.

MEDICAL CARE PLANS COMMITTEE

It was pointed out that this was one of Honolulu's elected committees. Dr. Spencer wanted to know why the request was made and it was explained that there were many things going on that the neighbor islands didn't know about. It was doubtful if the men from the neighbor islands could attend, and again it was pointed out that this committee didn't have anything to do with setting a fee schedule. Since the Honolulu president is not in a position to appoint members, the chairman could be authorized to invite neighbor island doctors to come to the meetings. Dr. Richert said a letter should be directed to the chairman. The Workmen's Compensation negotiations were discussed. Mr. Kennedy said it was not exactly a contract but more or less a gentlemen's agreement and nothing had to be signed. The matter of the neighbor islands had been discussed in these meetings and Honolulu county had advised the Workmen's Compensation Bureau that they could not speak for the other counties. The hospitals are also involved and they had to be contacted. It was explained that the misunderstanding about the HMSA contract was not the surgical fees so much as there was an error in the presentation and that was what brought up the matter.

BOARD OF HEALTH LEGISLATIVE POSITION

Dr. Nishigaya explained that under the state government there would be a reorganization of departments and there were two proposals affecting the Board of Health which Dr. Lee felt should be opposed. One is to make a separate mental health department and the other involves a change in the way indigent medical care is handled. It was felt that these questions were too complex to be answered in just one session and that we should review the original report of the Oahu Health Council. The matter of appointing special committees to look into these two proposals was discussed and it was felt that both sides should have an opportunity to be heard. Dr. Bergin reviewed his experiences as a government physician and stated that no one ever got around to defining his duties.

ACTION:

It was voted that the President form two ad hoc

(Continued on page 80)

HELP! **HELP THIS CHILD**
HELP REDUCE CARIES

F—DROPS (OHMART)
F—TABS
VFC—CAPSULES

3 CONVENIENT DOSAGES FOR CHILDREN OF ALL AGES

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PRESCRIPTION • PHARMACISTS
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why wine in Cardiology?



For generations without number wine has been extolled as an "effective stimulant" and, therefore, valuable aid to treatment in various types of cardiovascular disease. It was this peculiar property, no doubt, which prompted the poet, Salerno, some 800 years ago to write—"Sound wine revives in age the heart of youth."

Now, as a result of modern research, we are obtaining concrete evidence of the favorable physiologic action of wine to lend support to the empiricism of ancient usage.

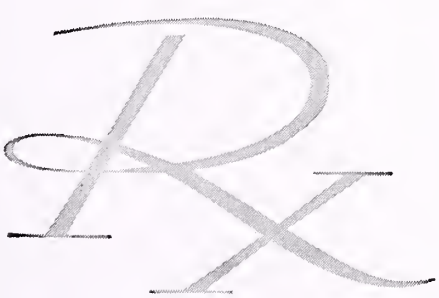
Both brandy and wine in moderate quantities have been found to substantially increase the pulse rate and step up the stroke volume of the heart.

Wine has been found to aid drug therapy in relieving the pain of angina pectoris and obliterative vascular disease.

Moreover, aside from the purely hypotensive actions of wine, its unquestionable euphoric effects help counter the depression, apprehension and anxiety so frequently present in sufferers from heart and coronary disorders.

The beneficial actions of wine appear to transcend those of more concentrated alcoholic beverages—valuable cardiotonic properties having been attributed to the aliphatic aldehydes and other nonalcoholic compounds recently isolated from certain wines and grape varieties.

It goes without saying that the use of alcohol, even in the form of wine, is contraindicated in hypertension accompanied by certain types of renal disease.



For a discussion of the many modern Rx uses for wine, write for the brochure, *"Uses of Wine in Medical Practice"* to Wine Advisory Board, 717 Market Street, San Francisco 3, California.

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

ROSIE CHANG, *Editor*

FLORA OZAKI, *Associate Editor*
KATSUKO ENOKI, *Associate Editor*
HAZEL KIM, *Associate Editor*
MILDRED KIM, *Associate Editor*

OLIVE C. PRIDGEN, *Executive Secretary*

1959 CONVENTION PROGRAM

Wednesday, October 14	1:00- 5:00 P.M.	Board of Directors Meeting Pre-registration, Oahu Delegates
Thursday, October 15	7:30- 8:00 A.M.	Registration, Oahu District
	8:00- 8:30 A.M.	Registration, Kauai, Hawaii, and Maui Districts
	8:30- 9:15 A.M.	Invocation and Devotional Service—Rev. Abraham Akaka, Pastor of Kawaiahao Church St. Francis Hospital School of Nursing Glee Club
	9:15-10:00 A.M.	House of Delegates Meeting, Official Welcome, Roll Call, Appointment of Tellers, Appointment of Resolutions Committee President's Address Report of Program Committee Report of Committee Chairmen, Officers, and Special Representatives
	10:00-10:15 A.M.	Coffee and Cokes—Visit Exhibits
	10:15-11:45 A.M.	House of Delegates, cont.
	11:45 A.M.	Chicken Luncheon—The Queen's Hospital Alumnae Association (Harkness Home Gardens)
	1:15- 2:15 P.M.	"Personality Needs in a Crisis Profession"—Dr. Mayer, Division of Mental Health, Hawaii Health Department, Hilo, Hawaii
	2:15- 2:30 P.M.	Coffee and Cokes—Visit Exhibits
	2:30 P.M.	Section Meetings
	4:45 P.M.	Boatride on "Kaimanu II" Picnic at Fort De Russy Officers' Club
Friday, October 16	8:00- 8:30 A.M.	Registration
	8:30- 8:40 A.M.	Invocation—Rt. Rev. Harry S. Kennedy, Bishop of the Episcopal Church of Hawaii
	8:40- 9:30 A.M.	Skit—Student Nurses Affiliating at Territorial Hospital
	9:30-10:00 A.M.	Coffee and Cokes—Visit Exhibits
	10:00-11:45 A.M.	"The Nurse—Crossroads of Emotional Crises"—Panel: Dr. George Harding, Assistant Director, Division of Mental Health, Hawaii Health Department
	12:30 P.M.	Luncheon—St. Francis Hospital Alumnae Association (St. Francis Hospital Dining Room)
	1:00- 2:30 P.M.	"Open Heart Surgery"
	2:30- 3:30 P.M.	"Latest Trends in Psychiatric Therapy"
	6:30 P.M.	Social Hour at Tripler Officers' Club
	7:30 P.M.	Luau-Banquet at Tripler Officers' Club "Air Medicine"—Colonel Hubert Miller, M.C., Sr. Flight Surgeon, Hickam Air Force Base
Saturday, October 17	8:00- 9:30 A.M.	Section Meetings
	9:30-10:00 A.M.	Balloting and Exhibits
	10:00 A.M.	House of Delegates, cont.

ACTIVE PARTICIPANTS IN THE NADO ROLL CALL are left to right, first row: Phyllis Smith, Charlotte Dennis, Jean Grippin (co-chairman), Lois Doublet, and Mamie Murakami. Second row: Esther Wagner, Hannah Richards, Elsie Park, Loretta Schuler, Ruth Thurman, Irene Kawamura (chairman), Yukiko Kojiro, and Pearl Ulukou.

Oahu Nurses on Parade

NADO President's Report

A varied and informative type program was planned for the year by the program and arrangements committees. Of special interest was Miss Donna Monkman's talk in February on the "Newer Trends in Nursing." In March, the meeting was devoted to discussion of the question, "Should the ANA and NLN Combine?" This is a question that is being asked today by many who are concerned with nursing and nurs-

V FOR VICTORY symbolizes the grand response to Roll Call for Nado! Left to right: Irene Kawamura (chairman), Hazel Kim, and Jean Grippin (co-chairman).





NATH'S FIRST DEAN OF NURSING, Dean Virginia Jones of the College of Nursing, University of Hawaii. A native of Indiana, Miss Jones first came to Hawaii in 1940.



OAHU NURSES LEARNING how to move a patient with a blanket litter are from left to right: Constance Carmody, Belle Broussard, Sybil Wong, and Margaret Rodearmel.

OAHU'S CHOSEN were selected for outstanding contributions in their fields. Rosie Chang, Flora Ozaki, Esther Higuchi, Mildred Kim, Eleanor Fern, Anne Camara, and Maki Yanagihara.



ing interest. Nurses feel the need to keep informed of the thinking that lies back of it and to know why such a question is being raised. The April meeting was held at the Kaiser Foundation Hospital where dinner was served in the hospital's gleaming modern cafeteria and where main dishes, including vegetables, came out of the microwave ovens (Radar Range) in a matter of seconds. An added attraction was a talk on the Kaiser Foundation Medical Plan given by Mr. Jacks, Hospital Administrator. There was a most enthusiastic turnout of NADO membership, visitors, and nurses who happened to be here on business from the neighbor islands. In keeping with the times and with the interest shown by women in making and handling money, a meeting was arranged in May for the discussion of this topic. Miss Marion E. King, head of Women's Customer Service, Bishop National Bank, was asked to speak on the subject. Her topic was, "Words for Wise Women."

It was voted upon by the Board of Directors and approved by the general membership that a sum of money be given to the Honolulu County Medical Library as a contribution from NADO toward the construction of the new building. A fund raising committee was formed to investigate methods for raising money for this purpose. The committee is now in the process of staging a Phantom Concert, an idea that has been used by mainland nursing organizations with success. It is hoped the same will hold true in the case of this attempt.

An event of historic interest for nursing organization in Hawaii took place in February when a School Nurse Branch of the Public Health Nursing Section was officially organized.

The NATH-NADO Legislative Committee has the wholehearted appreciation of the general membership for the hard work and splendid job done toward the successful passage of the Nursing Practice Act.

Plans for the convention began early in February of this year. A great deal of credit goes to the chairmen and members of the convention committees for early planning and much hard work.

The outstanding feature of this convention is that it will be the FIRST STATE convention for the nurses of Hawaii.

The convention committees have planned a program they hope will prove full of interest and enjoyment for all of you who attend the convention. Welcome to Oahu and to the First State Nurses' Convention.

(Mrs.) Dolores Wininger,
President, NADO.

NURSES' ASSOCIATION, DISTRICT OF OAHU

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NADO Standing Committees—1959

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Constitution and Bylaws: Shuku Wakayama, *Chairman,* Margaret Bennett, Sumiko Henna, Dorothy Ito, Betty Mitsunaga
Membership: Mrs. Norma Winston, *Chairman,* Irene Saito, Jean Yano, Jean Sakai, Joyce Fujinaka
Program: Charlotte Dennis, *Chairman,* Irene Saito, Sara J. Trainovich, Irene Kawamura, Jean Grippin, Ann Hudson
Arrangements: Olga Larson, *Chairman,* Sister Frances Cabrini
Nominations: Eleanor Fern, *Chairman,* Hilda Ferrick, Alma Takata
Legislative: Grace Smith, *Chairman,* Flora Ozaki, Olga Frojen, Loretta Schuler, Marjorie Wagner, Evelyn Young, Lulu Johnson, Dolores Wininger, Hazel Kim

NADO Convention Committees—1959

Program Committees

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Mrs. Mae Kuramoto
Miss Lily Toguchi
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Miss Clifford Burroughs, Co-Chairman

Exhibits Committee

Miss Takeko Hamasu, Chairman
Miss Faye Hayashi, Co-Chairman

Editorials

ANA Convention

Sister Maureen, President of NATH, and Mrs. Olive Pridgen, Executive Secretary, were among the 250 professional nurses from all parts of the country in Minneapolis during August attending conferences sponsored by the American Nurses' Association for representatives of constituent associations.

The first conference presented information and techniques to assist state representatives in improving effectiveness of their economic security program.

Immediately following this conference, Mrs. Pridgen attended a three-day meeting for executives of state and district nurses' associations. This second conference was focused on program implementation and administration.

NADO

This issue features Oahu, the third largest in square miles and by far the most populous island in the Hawaiian group. Oahu has an area of 604 square miles and a population of over 400,000. Long ago the capital island of the Hawaiian group was named Oahu which means gathering place. Modern history has made the name remarkably apt. Oahu is not only the political, cultural, and commercial center of Hawaii—it is the transportation center of the world's largest ocean, the "Crossroad of the Pacific."

Over 75 per cent of the nurses in the state of Hawaii work and live on Oahu. You will read about their accomplishments in the following pages.

President's Message

An excellent program was necessary to offset the summer heat at a Minneapolis meeting. The stimulating ANA Economic Security program was well worth the time spent by your President and your Executive Secretary.

Shades of a strike (now settled) among subsidiary workers in eight New York hospitals certainly brought into focus the necessity for a reiteration of the stand taken by ANA in 1950 to be effected in any geographical area where such a situation occurs. We quote:

> The ANA endorses the following as a guide to individual nurses for their proper conduct during employer-employee negotiations or disputes in their places of work:
>
> Registered professional nurses in an institution or industry as employees are accountable to management for the satisfactory performance of professional services for which they are employed, and at the same time, as licensed members of a profession, have direct legal and ethical obligations to patients.
>
> In addition, nurses, in recognition of the same obligations to patients, should maintain a scrupulously neutral position in regard to labor-management relations between their employers and nonnurse employees. Especially during any dispute which may arise, they should avoid any participation in activities designed to influence the outcome of the dispute, whether these activities are conducted by nonnurse employees or by management. They should neither, as partisans to the nonnurse employees, refuse or fail to carry out their proper and necessary nursing duties; nor, as partisans of management, accept the assignment of duties normally discharged by the nonnurse personnel unless a clear and present danger to patients exists.
>
> The ANA believes that the best relations among management, nurses, other employees, and the public will be maintained if management, the other employees, and the public recognize that nurses by virtue of their professional obligations occupy a neutral position in management-labor disputes and continue to perform their distinctive nursing functions during such disputes solely in fulfillment of their professional duties to the patient.

The eyes of many people—of the entire American public—have been turned on our profession because of the fear that care of the sick might be jeopardized. The guiding principles of action given by our national organization should leave no doubt in the mind of the public that nurses fully realize and accept their responsibility to protect their patients' welfare. Certainly by voluntarily relinquishing the right to strike professional nurses have made it clear and emphatic that their conduct should be motivated by abiding moral principles. The spirit of dedication remains the hallmark of our profession.



SISTER MAUREEN
President

Recognizing their obligations to protect the public welfare, nurses also, as citizens and individuals, expect to be protected by standards that will insure their own professional security. In Minneapolis, these standards were presented and discussed in an effort to demonstrate to professional members their common goals and the channels through which, by concerted effort, these objectives could be achieved. Nurses in today's society occupy a position of dignity dependent upon the fulfillment of goals they hold in common with all other human individuals. ANA summarized them in the following way.

1. The ability to work is generally essential to survival. In today's milieu, nurses need a medium of exchange and accept-

ance of their ideas in order to enhance their economic and professional security.

2. There is a recurrent need for exploring working conditions and implementing recommendations for improvement that are mutually acceptable to the nurse and her employer.

3. As a guide in employer-employee relations, a set of rules is essential to protect the nurse against capricious use of power and to safeguard her security. Nurses should be given an opportunity to participate in drawing up rules that will affect them.

4. If inequities arise, a channel is necessary to review and, if necessary, to change the regulations, and nurses should have access to this channel.

5. Nurses should be allowed opportunities to discuss means of maintaining their individual professional standards by evaluating quality, exercise of judgment, performance, and professional self-government.

Across the continent, state nurses' associations are actively engaged in assisting their members to develop constructive economic security programs. ANA has published a manual for guidance. We were privileged in previewing rough drafts of study guides soon to be made available to promote understanding and use of techniques to provide and maintain a sound professional economic security program.

The Minneapolis workshop probed many problems, offered some solutions, and unfolded challenges for nurse leaders in local units. Filmstrips and movies were included in the program. Faculty participants included Professor J. Benton Gillingham, Department of Economics at the University of Washington; William Nunm, Director of University of Minnesota Public Relations; Deryle Feldmeier, Managing Editor of the Minneapolis Tribune; Leon Despres, Legal Counsel of the Illinois Nurses' Association. ANA specialists also made valuable contributions. Judith Wallin sent her aloha to the nurses in Hawaii whose graciousness seems to have left an indelible impression on her.

Mrs. Pridgen remained for the Executive Secretaries Conference while your President headed east for an Institute at Notre Dame University. My flight companion to Chicago was, happily, Mary Kuntz, President of the National Student Nurses' Association. She is a senior at Grant Hospital School of Nursing in Columbus, Ohio. Her awareness of the problems and goals of her profession certainly impressed me with the potential leadership of our student nurses that should be cultivated for the future.

In conclusion, this provocative workshop raised many questions that should be analyzed and answered by professional nurses in Hawaii. Where are we now, where are we going, and how shall we arrive at the goals of a sound economic security program?

General Interest

American Nurses' Association

The following is a statement made on May 18, 1959, by Julia C. Thompson, Washington Representative, to the Senate Committee on Appropriations and the Subcommittee on Departments of Labor and Health, Education, and Welfare and Related Agencies:

I am Julia C. Thompson, Washington Representative of the American Nurses' Association, the national organization of registered professional nurses. The ANA has over 190,000 members in 54 constituent state and territorial associations. I appear here today to present the Association's views on certain items relating to nursing in the budget for the Department of Health, Education, and Welfare in H.R. 6769. The ANA is vitally interested in all programs of the Department of Health, Education, and Welfare and believes in the principle of federal support for research and public health programs. In discussing budget allocations, however, the ANA believes it should restrict its comments to those items directly related to nursing on which the profession is competent to speak.

We were pleased to note that the items on which we wish to speak were mentioned in the report accompanying H.R. 6769 from the House Committee on Appropriations. On page 11, the report states, "The Committee was impressed with the testimony concerning the work of the Division of Nursing Resources and hopes that efforts will be made to facilitate this important work."

On page 9, the report states, "The Committee's attention has been called to the career development program of the Division of Public Health Nursing. Little, if any testimony has been given on this subject by the Public Health Service officials. The Committee hopes this is not an indication they feel such a program is unimportant, and expects more information on it during next year's hearings."

The Division of Nursing Resources in the Bureau of Medical Services, Public Health Service, has, over the past ten years, worked to develop methods of increasing the nation's nurse supply. The Division has through research, the application of research findings, and consultation on a national scale assisted in the improvement of nursing service for our nation's people. Service to states on resource and utilization studies has been a major contribution. In this effort the Division

supplies qualified consultants to states which finance their own studies. Such help has been invaluable in improving nursing care and in determining the discrepancies between the demand for nursing service and the supply within the 40 states served.

Requests for assistance and the need for expansion of the work carried on by the Division of Nursing Resources go far beyond what the Division can do within the $330,000 item allocated in the current budget. Present requests for service and present needs for the work of this Division would, under current budget limitations, keep the Division busy for the next two years. This would allow nothing with which to meet requests and needs in the months ahead. In addition, it is vital that the Division have funds to expand its consultant service to assist states, hospitals, and other agencies to apply the findings of research in improving nursing care. It is through the application of these research findings that nursing care will be improved.

Further research is needed to find ways to increase the numbers of nursing personnel, to make better use of the skills of available nursing personnel, to improve and develop new skills as health care advances, and to remove obstacles which impair the functioning and recruitment of nurses. Therefore, the American Nurses' Association urges that $1 million be appropriated for the Division of Nursing Resources in the Public Health Service, the only research center for nursing in a government agency.

The need for expansion of research in nursing and the training of nurses qualified in this area is so great in the eyes of the nursing profession that the Association's House of Delegates approved the furtherance of such research as one of ANA's primary goals at the national convention in June, 1958. The goal states that ANA will ". . . stimulate efforts by nurses and other specialists to identify and enlarge the scientific principles upon which nursing rests and to encourage research by them in the application of these principles to nursing practice."

As more and more research is conducted in specific disease categories and other health areas, we need qualified nurses as part of the research teams. Observations and judgments require not only a knowledge of research principles and techniques but of health care, treatments, and patient reactions as well.

Since 1955, funds have been earmarked within the allocation to the National Institutes of Health for research projects and fellowships in nursing. The need for such funds is evidenced by the rapid growth of this program within the budget allowed —from $\frac{1}{2}$ million four years ago to about $1 million this year. Even with $1 million, many eminently qualified persons had to be refused funds.

We were pleased to note that on page 16, the report from the House Committee on Appropriations states, "Another small but important activity financed with these funds is the program of nursing research fellowships and grants. The Committee has provided sufficient funds in the bill so that this important program can be adequately financed."

H.R. 6769 includes $36,404,000, for General Research and Services, $7,430,000 more than the amount appropriated for 1959. We assume from the report that the committee has provided for nursing research in this increase. The American Nurses' Association urges that at least $2 million be earmarked from the total for fellowships and projects in nursing research under the National Institutes of Health.

Last year the former Public Health Nursing Branch was made the Division of Public Health Nursing in the Bureau of State Services. At the time, ANA commented favorably on this reorganization which, we believe, will improve the effectiveness of nursing service. Although the nursing service has been accorded this status, funds for the new Division are not separated in the total budget allotment for this area. Adequate funds must be assured the new Division in order for it to carry out its important role in the nation's public health program.

One of the Division's most important activities, benefiting federal, state, and local public health services is the Career Development Program. In the middle and late forties, about 20 nurses were being trained on assignment to local and state public health services as part of this program. At the present time, only four of these training positions are provided in the budget. This number is not sufficient to take care of attrition, much less the expansion of service into areas of chronic disease and accident prevention. It is known that during the past eight years, 39 nurses were separated from the service and only 21 were recruited. Undoubtedly, retirement was only one of a number of reasons for these separations. However, judging from the ages of nurses now in the service, retirements in the future will widen this gap unless additional training positions are provided. Only eight of the nurses now in the service are 39 years of age or younger, 47 are over 50, and the remainder are over 40.

Although other divisions and branches within the Public Health Service can recruit nurse personnel themselves, they usually look to the Division of Public Health Nursing for assistance. With

only four positions budgeted, the Division must find it impossible to meet such needs for areas such as Indian Health and Heart Disease Control. It would be disastrous to recruit nurses to such services who had not had supervised work in public health, such as that provided by the Career Development Program.

The ANA believes the Division of Public Health Nursing should have the funds necessary to carry on an adequate program in this area. We believe a minimum program would include 22 training positions, which would mean an addition of 18 to the present four at an additional estimated cost of $94,500. The ANA urges that funds be allowed to provide for these 22 training positions.

Among the very successful programs handled by the Division last year was the extension teaching program offered at the University of Minnesota. Faculty was provided by the Division and over 400 nurses attended these sessions. This type of service strengthens and improves state and local health department nursing programs by bringing educational opportunities to many public health nurses who cannot leave their jobs and homes for extended study elsewhere. Such programs are vitally important when you consider that of the estimated 24,100 public health staff nurses practicing today, only 22.8 per cent[1] hold bachelor's degrees, the educational requirement considered basic for these positions.

In conclusion, I would like to summarize the budget allocations which ANA believes are necessary to the continued improvement of nursing care for the people of this country:

1. We urge that Congress appropriate $1 million for the work of the Division of Nursing Resources within the Bureau of Medical Services, Public Health Service.
2. We believe that $2 million should be earmarked for nursing research fellowships and grants within the funds allocated for General Research and Services under the National Institutes of Health and administered by the Division of Nursing Resources.
3. We urge that funds be provided to expand the Career Development Program of the Division of Public Health Nursing, permitting 22 training positions, where now there are only four.

On behalf of the American Nurses' Association, I thank you for the opportunity of appearing before you to present the views of nurses on these appropriation items now before your committee.

[1] Levine, Eugene: How many nurses now have college degrees?, Nursing Outlook (Dec.) 1958.

Book Reviews

Study Guide and Review of Practical Nursing. 2d Ed.

By Helen F. Hansen, R.N., M.A., 398 pp., $4.25, W. B. Saunders Company, New York, 1958.

An advanced but complete study guide and review of nursing with outlines of subjects and integrated situations-type questions and answers. Besides the usual sections on structure and functions, nutrition, nursing of the mildly ill and the aged, etc., there are interesting but short reviews on community health and microorganisms. An informative and helpful section on vocational relationships is included. The number, placement, and clarity of anatomical charts is valuable.

J. Ortelt, R.N.

Fundamentals of Chemistry. 8th Ed.

By L. Jean Bogert, Ph.D., 615 pp., $5.50, W. B. Saunders Company, New York, 1958.

As a text for students of nursing, this book adequately covers the three areas of inorganic, organic, and physiological chemistry. The format is attractive and conducive to learning. The many and varied types of illustrations are helpful. An excellent textbook for a 90 to 100 hour course or as a reference when a more elementary text is used.

C. Burroughs, R.N.

Fundamentals of Inorganic, Organic and Biological Chemistry. 4th Ed.

By Joseph I. Routh, Ph.D., 384 pp., $4.00, W. B. Saunders Company, New York, 1959.

While a somewhat more elementary text than the majority offered in this area it illustrates the basic principles of chemistry that a nurse should know. The organization is good and easy to follow. The review questions are especially helpful and point up applications of chemistry to physiology. A valuable text which may readily be supplemented by assigned readings in areas which seem inadequate, i.e., that of atomic energy.

C. Burroughs, R.N.

Urologic Nursing, 6th Ed.

By David M. Davis, Kenneth C. Warren, 196 pp., $3.75, W. B. Saunders Co., 1959.

This book was written in an attempt to cover urology and urologic nursing in a brief and practical manner. It is very successful in presenting to the reader a wealth of material in an organized, clear, and concise manner. The book covers whatever is commonly found in urologic nursing and is therefore adequate as a textbook. However, it cannot be used if the reader wishes a detailed and comprehensive coverage of the subject.

Ruth Lam, R.N.

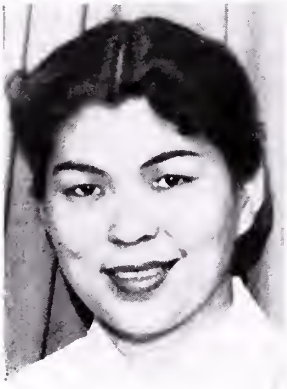
HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

LYDIA C. MARTENS, *Editor* ETHEL NISHIBATA, *Associate Editor*

President's Letter

The Hawaii Society of Medical Technologists has just seen the close of a tremendously successful year in the line of accomplishments in our educational program, both scientific and public.



MISS MATSUO
President

Many, many thanks to Miss Clara Yuen, our past President, from all of the members of the Society for her excellent stewardship and tireless dedication to administrative responsibilities. I hope that I will be able to do as well.

The Nomination Committee has given me an excellent slate of officers and I look forward to working with them and the various committee chairmen in bringing you a progressive program.

With the interest and cooperation shown by all of the members the past year, we cannot help but see the coming year as one of much growth and progress. Thank you.

Standing Committee Chairmen for 1959-60

Membership: Takeyo Saito—Tripler General Hospital
Legislative: Mun Fook Shinn—Leahi Hospital
Program: Elaine Chang—The Queen's Hospital
Lorene Leong (Co-chairman) The Queen's Hospital
Scholarship: Beatrice Sakai—Occidental Laboratory
Constitution: Louise Wulff—Territorial Hospital
Edith Eckstein (Co-chairman) Tripler General Hospital
Education: Loretta Pruss—Professional Medical Laboratory
Convention: To Be Announced
Civil Defense: Ellen Chun—Chock-Pang Clinic
Finance: Jack Furuta—St. Francis Hospital
Sanae Nakamura (Co-chairman) The Queen's Hospital
Nomination: Mildred Lee—The Queen's Hospital
Public Relations: Felice Kaulukukui, Maluhia Hospital
Recruitment: Helen Chong, Straub Clinic
Publications: Lydia Martens—Kauikeolani Children's Hospital
Ethel Nishibata—Leahi Hospital

Report of the Annual Convention of the American Society of Medical Technologists, Phoenix, Arizona, June 14 to 19, 1959

LOUISE WULFF
Delegate from Honolulu

Since this was my first attendance at a national Medical Technologists' Convention I may be a trifle over-enthusiastic. I had anticipated a good time and stimulating courses, but I was really unprepared for the stature of the speakers and exhibitors, the evident talents and abilities of the technologists themselves—in fact, the magnitude of the whole convention.

When I got off the plane at Phoenix the blast of heat that came up in waves off the pavement was equaled only by the warmth of greeting that was extended to Hawaii's *STATE* delegate by the technologists at the opening reception, and throughout the whole week! It was truly a wonderful year to be the delegate from Hawaii, everyone was so interested and pleased about us—I do believe the Mainlanders were more excited about statehood than we!

KEYNOTE ADDRESS

Doctor Mervin H. Grossman, Assistant Professor of Clinical Pathology at Southwestern Medical School in Dallas, Texas, opened the convention with an address entitled "Growth Through Competence." He told of the growth the Society of Medical Technologists has already made, what we can do to grow further, and what things will keep us from growing. He decried the large number of registered technologists who are not also members of ASMT, disinterested members within the society, and the lack of really superior technologists. On the positive side he saw good in the increased training requirements, the increase in the number of male technologists, the trend toward profit-sharing in independent labs, and better starting pay throughout the country. (Inexperienced registered techs in Dallas are started at $400.00). He also noted a general increase in efficiency and productivity.

As necessary characteristics for individual growth, Doctor Grossman listed essential alertness and awareness, the ability to advance techniques, and, in these days, even to be able to change basic

concepts. The mark of a professional, he said, comes from within; it is attitude and feeling and includes long and arduous training, self-sacrifice, and a relegation of pay to secondary importance. Competence, he said, is made up of knowledge, skill, and responsibility—the knowledgeable man is the eternal student, skill depends on practice, and responsibility is a personal recognition of duty. And in the laboratory the quality of the work must never be cut.

Answering a trend of some segments of ASMT toward disassociation with ASCP, Dr. Grossman warned that we could never be independent of that group because we are practicing medicine without a license and the the license we practice under belongs to our pathologist. This controversial bit brought about many discussions later. Just when does chemistry become medicine and is a lab. report a scientific clue to diagnosis or is it more than that? Dr. Grossman's talk stimulated a great deal of thought and maybe his somewhat arbitrary statements were intended to jolt us into action.

MEDICO-LEGAL MATTERS

Dr. Harry P. Smith, Professor of Pathology at Columbia University told of the increasing number of civil suits being brought against technologists and pathologists and the need for each of us to check his own hospital liability policies, for they vary greatly. He strongly emphasized that neglect and liability are personal. Once a hospital was held responsible for the acts of its employees but now more and more the liability is placed on the individual and suit is brought against the nurse, doctor, or medical technologist involved.

Although to date, there has not been a suit against a technologist in the islands, it *could* happen here, so it might be well to find out what insurance is available to us.

A DIFFERENT APPROACH TO DIFFERENTIALS

Dr. Mathew Block, Associate Professor of Medcine and Hematology, at the University of Colorado Medical School, devoted his seminar on hematology to the peripheral blood smear. His main plea is for less time spent on repetitious routine and more time given to diagnostic study. To gain this time in a busy clinical lab he makes the radical proposal of not counting a differential, but having it scanned by experienced technologists who would merely report the cells as "Normal in appearance and number." If the slide were not normal, then a count and further study could be made.

In his discussion of techniques of preparing smears Dr. Block brought out nothing new but redirected attention to the importance of a well made smear. He differs from standard directions for examining the smear by suggesting that the trailers as well as the body of the smear be given close attention and that counting be the long way, from thick to thin area rather than across the slide. Low power examination should always be made and a report that does not mention the platelets is not complete. Dr. Block illustrated with slides the abnormalities of rbcs, wbcs, and platelets that may be found in a peripheral smear. When asked how the routine orders could be eliminated Dr. Block laughed and said we would need strong pathologists to run interference for us.

SEMINAR ON MICROBIOLOGY

Dr. Harry Harding, Associate Professor of Microbiology at Northwestern Medical School, presented a most interesting session. We were provided with data on five different patients including admission symptoms, histories, initial laboratory and x-ray work. We were then asked to list several probable diseases for each patient, and to tell what specimens should be collected to help with a correct diagnosis. We were to tell how and when the specimens should be collected and the principal methods we would use to arrive at a microbiological diagnosis. The cases were very interesting and somewhat tricky. Following the fun of figuring a possible diagnosis, the discussion of methods was most informative. A 29-page manual given us contains a practical outline of routines to follow. The enteric culture routine as used by the Evanston Hospital is the same as that followed by the Territorial Board of Health lab (and by us here at Territorial Hospital). Dr. Harding alerted us to the possibilities of finding schistosomiasis among patients who come from Puerto Rico. (The disease cannot be contracted here since we do not have the host snail in Hawaiian waters.)

SENSITIVITY TESTING

The luncheon round-table discussion groups were all well attended and very lively. They lasted well into the afternoon. Dr. James Barger, pathologist from Phoenix was moderator of the sensivity testing group which I attended. He suggested, as a time saver, using only the three most widely used discs on the heavily inoculated portion of the initial plate. A more complete testing done on plates made from colonies picked from the same original plate or from the broth culture can then be made, but in the meantime the doctor can be given a preliminary report to work on Dr. Barger emphasized the necessity for using sheep's blood for plate making. There was some debate on this. However, most of the technologists there are presently using sheep cells for blood plates.

These successful round-table meetings demonstrated very well the need for good moderators

at such meetings which could easily have deteriorated into a mere recital of "What we do in *our* lab." The skillful leadership kept the discussions lively and thought-provoking.

CONSTITUTION AND BYLAWS CLINIC

Miss Mae Hoffman, National Chairman of the Constitution and Bylaws Committee reviewed for us the proposed changes in the National constitution and reasons for making them. She gave us practical help in drafting proposed changes and in keeping the state committee's files current. She also reviewed procedures for presenting material to the national society for consideration.

GETTING THINGS DONE

The session on parliamentary procedure was unexpectedly amusing. Mr. John E. Sembower, attorney from Indiana and Parliamentarian for ASMT, has a homespun sense of humor and an easy, informal delivery. But for all the informality of his "Clinic," as he called it, Mr. Sembower's talk was most informative. I find I have pages of notes on his talk. Briefly, he told us (and the captions are his): 1. How to keep score. 2. How to get your say, no matter what. 3. How to get rocks out of the road. 4. How to rewrite the rules if you don't like 'em. Every officer and committee chairman should have heard him. It was very amusing later in the House of Delegates meeting to see some of his suggestions being put to use, i.e. a controversial resolution that threatened to hold up all further business for hours was sent back to committee, etc.

MULTIPLE MYELOMA

Dr. Charles E. Strickland, Associate Pathologist at the University of Tennessee, defined and described the symptoms of the disease. He then discussed other similar diseases with similar findings and the importance of globulin variations in diagnosis. Here electrophoretic studies prove their worth. Dr. Strickland mentioned both the usual and possible lab findings, i.e., rouleaux formation in peripheral blood smear, the difficulty of accurate blood typing, high calcium and BUN, the presence of plasma cells, and Bence-Jones protein in the urine.

HOUSE OF DELEGATES

I have said it was wonderful to represent Hawaii this year—Hawaii was cheered on all occasions. I didn't even have a chance to answer roll call, the rest of the delegates cheered when Hawaii was called. Toward the end of the Thursday afternoon session I was given time to extend Hawaii's invitation to the National Society for a post-convention here in the islands following the Seattle meeting in 1961. Complete in my very best tutumuu, Kona hat, and slippers I made the invitation with a liberal sprinkling of Hawaiian words, used correctly, I hope. The enthusiastic response to the invitation was terrific. The Wisconsin delegation declared they were all going to stay home in '60 to have enough money to come here in '61. We can count on about 150 to 200 visitors in 1961.

There were many important items of business, chiefly, of course, the amendments to the bylaws. A report on actions taken at the Delegates meeting will be made to the Hawaii Society later.

The convention was a great success and for me a rewarding personal experience. I cannot urge strongly enough that our active members attend when they can, certainly we owe it to our Society to send our President-Elect each year. It is stimulating to meet the top technologists of the country and the scientists they work for; to attend the seminars and exhibits and learn of the new discoveries, methods, and techniques; to see a well run organization in action; and to experience the friendliness and hospitality of so many fine people. And while this *kuaaina* from Kaneohe got a great deal out of it all, I'm sure that some of our younger, more recently trained Medical Technologists would come back with even more —at least, in a practical way. Mahalo for electing me to represent the Hawaii Society of Medical Technologists. I'd like to go *every* year!



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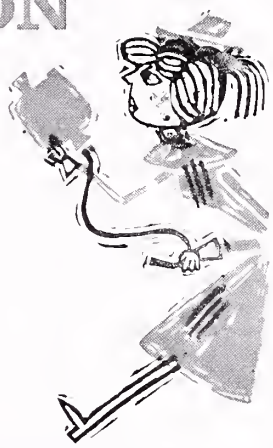
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HAWAII MEDICAL ASSOCIATION

(Continued from page 63)

committees, one to deal with the problem of indigent medical care and the other to deal with the subject of mental health; that these committees be instructed to work with the departments involved; and that reports be made before the opening of the next legislative session.

MISCELLANEOUS BUSINESS

There was critical discussion of a recent letter to the editor of the "Advertiser" which had appeared in the morning paper and was carried under the caption "Physician Critical to Burns." It was felt we should let Jack Burns know there was no question of our feelings about his integrity during this era and that at that time we had a very high regard for his conduct.

The importance of the next annual meeting, and whether or not it should be publicized to county societies throughout the Mainland as the first meeting under statehood, was next discussed and it was decided that this suggestion be passed along to the Arrangements Committee.

Dr. Burden brought up the problems facing the Hospital Advisory Committee. He said that it had become apparent to him that the Board of Health considers the Committee nothing more than a rubber stamp committee and as long as they approve of the recommendations that the Board of Health makes, all is well, but a recommendation which the Board of Health does not wish is ignored. Why have a hospital advisory committee if their reports and recommendations are not paid any attention to? The most important one was in regard to the Windward Hospital. Other things of a more minor nature have occurred. The Committee never knows what the Board of Health does about their reports. Dr. Nishigaya asked if the committee were appointed by the Governor and was advised that it was. Dr. Burden said one time after they had made recommendations, the committee was not called to meet for nine months. Dr. Allison said he felt a great deal of sympathy because he was on one of those committees to the Board of Health, not the Department of Health. and that these two should not be confused. Dr. Nishigaya said the Committee could write to the HMA stating their complaints and if the Council approves, they could send a letter to bring the matter out officially. Dr. Burden asked if Honolulu County had taken an official action on backing the idea of the Windward Hospital and was advised that they had. Also the Legislative Committee of the HMA approved it if it doesn't become a burden to the taxpayer.

The meeting was adjourned at 10:45.

RAYMOND C. YAP
Secretary

COUNTY SOCIETY REPORTS

(Continued from page 56)

desired active membership in the Society in the area in which he now resides, therefore making it necessary for him to resign from this Society. The Board felt that in view of Dr. Alsup's long service to the Society, he should be given an honorary membership.

The 1959 budget (copies of which had been circulated to the membership prior to the meeting) was brought up for discussion and approval. There being no questions, it was moved, seconded and passed that the annual budget be accepted as proposed by the Finance Committee and as approved by the Board of Governors.

Dr. Moore was asked to discuss the matter of the increasing of income levels for HMSA medical plans as approved by the Board of Governors at their last meeting. He stated that the Medical Care Plans Committee was very concerned about this increase which was not what the committee had recommended in their final report to the membership and which the membership had approved. A letter from the Medical Care Plans Committee was read which took note of this increase as approved by the Board of Governors and recommended that the levels as approved by the membership be accepted with one modification.

It was felt that since the letter was addressed to Dr. Richert it should first go to the Board of Governors for review.

It was moved by Dr. West that this matter be referred back to the Board of Governors for reconsideration, in that they did not have this information at the time they passed on the income levels. The motion was seconded and passed.

Dr. Batten briefly reported on the Medical Library's building fund and reminded the doctors of the annual meeting of the Honolulu County Medical Library on January 13.

There being no further business, the meeting was adjourned to the lanai where refreshments were served.

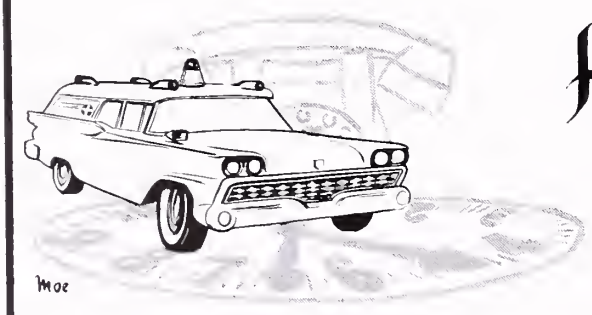
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Dr. T. H. Richert presided at the Feb. 3 meeting and approximately 100 members were present.

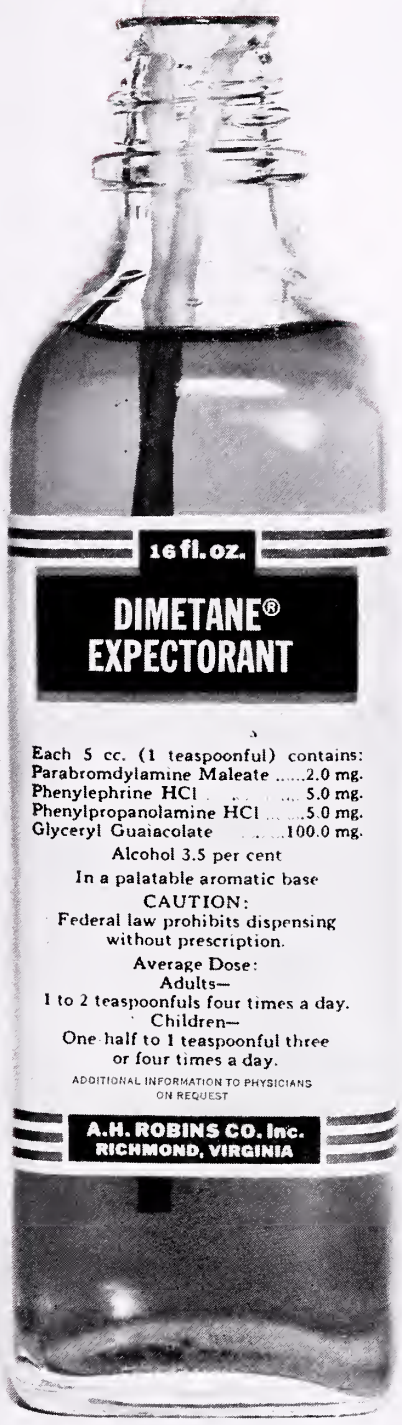
A 22-minute movie on "Skin Diving in Mexico" was shown followed by a talk on "Taravana" (Pearl Diver's Disease) as observed by Mr. E. R. Cross, and a talk on the "Diagnosis and Treatment of the Bends" by Dr. L. F. Stock. A question and answer period followed.

A letter from the Medical Care Plans Committee was read, regarding the HMSA income levels. The membership was informed that the Board of Governors had approved the income levels as proposed by the committee.

(Continued on page 82)



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the straws just symbolize the good flavor! And DIMETANE EXPECTORANT for cough is as effective as it is delicious. FORMULA: each 5 cc. (1 teaspoonful) contains: DIMETANE (Parabromdylamine Maleate) 2.0 mg.; Glyceryl Guaiacolate 100.0 mg.; Phenylephrine Hydrochloride, USP 5.0 mg.; Phenylpropanolamine Hydrochloride, NNR 5.0 mg.; Alcohol 3.5% in a good-tasting aromatic base.

works better

combines the unsurpassed antihistamine Dimetane with the clinically proven expectorant glyceryl guaiacolate (which increases R.T.F. almost 200%) and two recognized decongestants. When additional cough suppressant action is indicated, prescribe DIMETANE EXPECTORANT-DC, which provides the basic formula with dihydrocodeinone bitartrate 1.8 mg. per 5 cc. (exempt narcotic).

Dimetane® Expectorant

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(WITH DIHYDROCODEINONE BITARTRATE 1.8 MG./5CC.)

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COUNTY SOCIETY REPORTS

(Continued from page 80)

Dr. West moved to accept the Board's recommendation. The motion was seconded.

A discussion followed during which Dr. Inouye asked if this increase of income levels would be put into effect with the present fee schedule. In answer to this question it was brought out that the new income levels would take effect the same time a new revised fee schedule went into effect.

Dr. Moore spoke at length on the letters received from the various county societies in the Territory. He stated that it was indicated from these letters that the outside island doctors have not been properly informed as to the negotiations this Society was having with the HMSA. It was apparent from their letters that certain representatives from the HMSA had either misrepresented the facts or had neglected to give the entire picture. He went on to say that the Medical Care Plans Committee is in the process of preparing an answer to the letter from the Hawaii County Medical Society with copies being sent to the other counties and HMSA. It was the feeling of the membership that Dr. Moore's committee was following the proper procedure in this matter.

Dr. West spoke briefly on the difference of the economic conditions between the various islands and brought out that perhaps there should be a fee schedule for Honolulu and one for the various outside islands.

Dr. West's motion to approve the income levels as recommended was voted on and was passed with two dissenting votes.

(Continued on page 86)

If he needs nutritional support . . .



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Supplied in two potencies for dosage flexibility:

MILPREM-400, each coated pink tablet contains 400 mg. Miltown (meprobamate) and 0.4 mg. conjugated estrogens (equine).

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Both potencies in bottles of 60.

Literature and samples on request.

In minutes, Milprem starts to ease anxiety and depression. It relieves insomnia, relaxes tense muscles; alleviates low back pain and tension headache. As the patient continues on Milprem, the replacement of estrogens checks hot flushes and other physical symptoms.

Easy dosage schedule: One Milprem tablet t.i.d. in 21-day courses with one-week rest periods; during the rest periods, Miltown alone can sustain the patient.

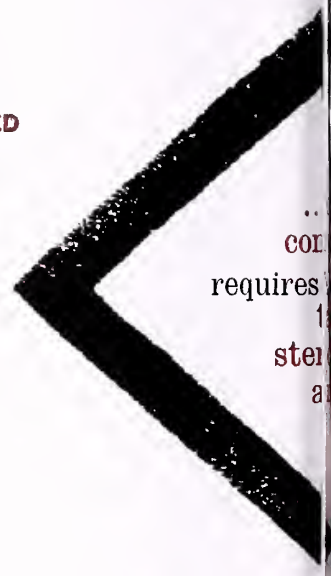
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is more
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alone
can control...

MORE
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ARISTOGESIC is particularly effective for relief of chronic – but less severe – pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

ARISTOCORT® Triamcinolone	0.5 mg.
Salicylamide	325 mg.
Dried Aluminum Hydroxide Gel	75 mg.
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Supply: Bottles of 100 and 1,000.



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LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

COUNTY SOCIETY REPORTS

(Continued from page 82)

Dr. T. H. Richert presided at the March 3 meeting and approximately 182 members and guests were present.

Dr. Henry J. Tumen, 1959 postgraduate speaker, presented a lecture entitled "The Pathogenesis and Differential Diagnosis of Jaundice."

Drs. Cora Lee Au, Alma L. Chun, Francis T. C. Au and Caesar B. deJesus were welcomed into the Society as new members.

Dr. Batten reported on the present status of the Library building fund which at present totals $87,500.00 and is only 20% of their goal. He urged 100% participation of the doctors.

* * *

Dr. Richert presided at the April 7 meeting. Presentation of awards made to local contestants in the 1959 Association of American Physicians and Surgeons Essay Contest.

Mr. Robert Midkiff of Hawaiian Trust Company spoke on "New Investment Opportunities for Doctors." His talk included a discussion on: Social Security for Doctors; Simpson-Keough-Bill—Retirement of the Self-Employed; and Real Estate Investment in the State of Hawaii.

The minutes of the previous meeting were approved as read. Dr. Fumiyo Sugimoto and Dr. Donald M. Wright were welcomed into the Society as new members.

HMSA Fee Schedule Changes

Dr. Richert brought out that the Medical Care Plans Committee has now completed the job of converting the HMSA fee schedule to the Honolulu County Medical Society's Relative Value Schedule. However, there are a few recommended changes which need to be acted upon by the membership before the committee can complete negotiations with HMSA. These changes were circulated to the membership prior to this meeting.

Dr. Moore was asked to explain the major changes as recommended by the committee and which were as follows:

I. Procedures 3315, 3316 and 3317, all having to do with Proctoscopy, was changed from the present unit value of 15, 10 and 20 to a unit value of 10, 6 and 12.

ACTION:

It was moved, seconded and passed that Recommendation I be accepted.

II. Procedure 5961—Myringotomy: Tympanotomy; plicotomy—will be listed at $9.00, and will carry the following footnote: "Necessary care following this procedure will be billed as medical management and HMSA will allow medical benefits."

It was explained that a doctor performing this operative procedure may bill HMSA for $9.00 and all follow-up care will be charged under medical management. The doctor is therefore not limited in his charges, but HMSA will only pay $3.00 per visit up to the limit of the patient's policy. If the patient does not have medical coverage then these charges will be the responsibility of the patient.

ACTION:

It was moved, seconded and passed that Recommendation II be accepted.

III. It is recommended that Section 14, para. 2, of the HMSA Manual "Administrative Instructions and Procedures" be amended to read as follows:

(Continued on page 93)



they deserve

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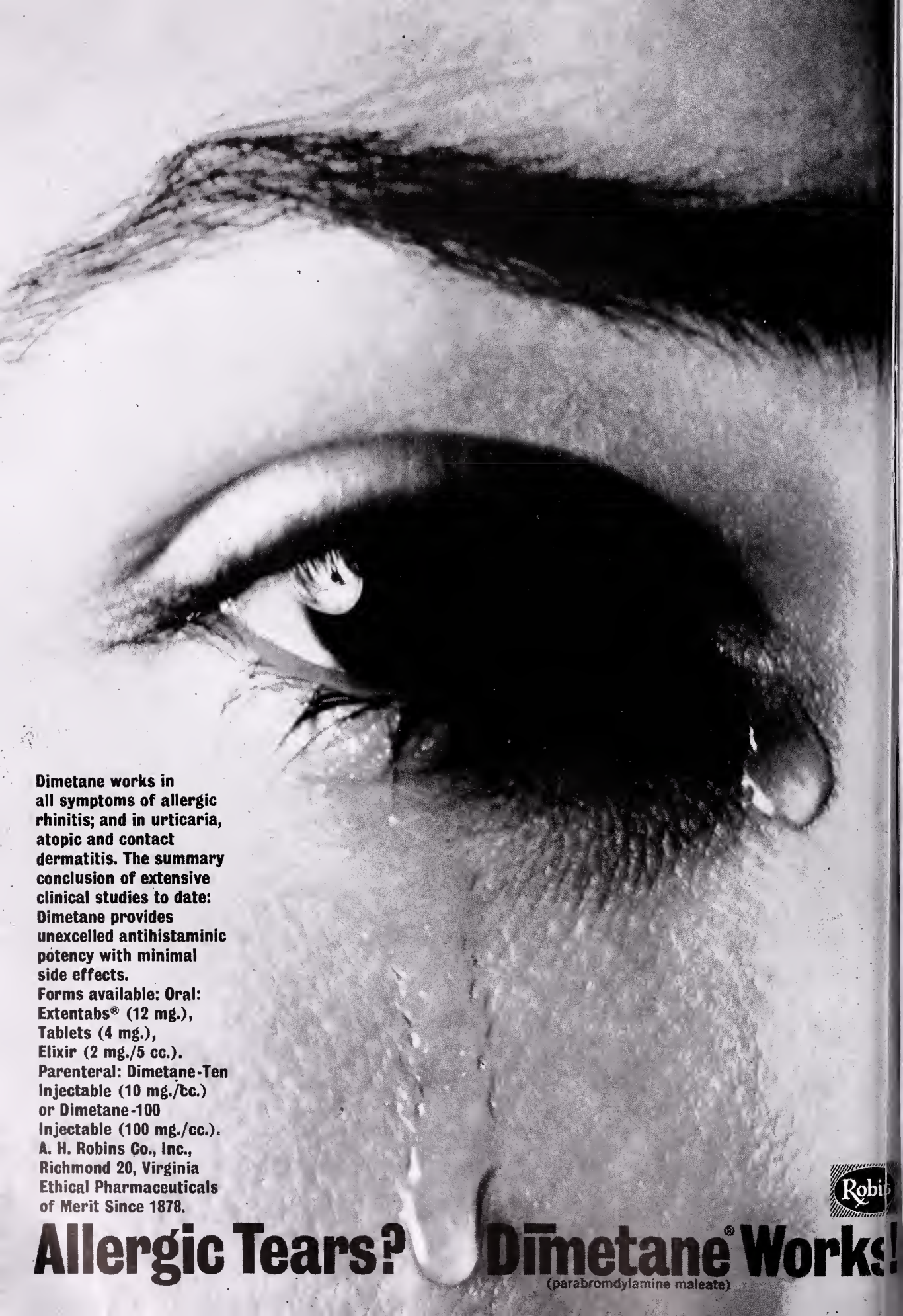


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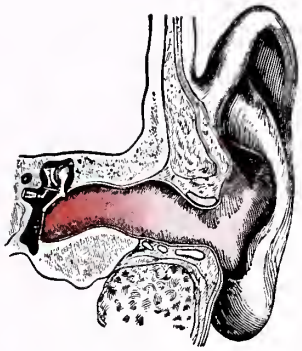
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Comprehensive bactericidal/antifungal action — eradicates *Pseudomonas* and most other common causes of otitis. Hygroscopic; restores normal acid mantle.

Each cc. contains:
'Aerosporin' brand Polymyxin B Sulfate ..... 10,000 Units
Acetic acid 1%
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2 'CORTISPORIN'® brand Otic Drops

Broad-spectrum bactericidal action plus effective anti-inflammatory and antipruritic therapy. Eradicates most common causes of otitis; restores normal acid mantle.

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Neomycin Sulfate ..... 5 mg.
Hydrocortisone in a sterile, slightly acid, aqueous suspension ..... 10 mg.
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Acts quickly to relieve pain and itching associated with otitis externa. Bactericidal/antifungal action — eradicates *Pseudomonas* and most other common causes of otitis. Hygroscopic; restores normal acid mantle.

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Propylene Glycol q.s. Sterile
Available in dropper bottles of 10 cc.

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Literature available on request.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

"Case Histories in Hypnotherapy"

Hypnosis, categorized as a mystic concept for centuries, has in recent years been the subject of clinical research and careful evaluation until more and more practitioners are accepting it as a valuable tool to augment their growing list of scientific aids and to complement or extend their field of treatment.

In the new book "Case Histories in Hypnotherapy" the findings of an independent research are recorded in case-by-case histories in great detail. The book also tells of the new techniques and how the inexperienced hypnotist may avoid the pitfalls that lead to failure.

Explicit step-by-step methods of inducing Hypnosis are explained in precise instructions with check points during the treatment session, whereby the physician may evaluate the degree of depth the patient has attained or whether he is accepting or rejecting the suggestions put to him.

These "check points" or reactions to the casual observer are so slight that they are nearly always overlooked by the inexperienced, but offer very significant clues that enable the hypnotist to proceed with his suggestions or abruptly change or modify his technique.

Every physician, regardless of his specialty, should have this work in his library, for it not only relates to actual case histories, but also evaluates the various methods and procedures and describes in detail the new concepts in this new therapeutic treatment.

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BOOK REVIEWS

(Continued from page 53)

perior quality. This reviewer recommends it unconditionally. It should be available for ready reference to every house officer and it is strongly recommended as a permanent addition to the practicing surgeon's library.

GROVER H. BATTEN, M.D.

Heredity Counseling

Edited by Helen G. Hammons, 112 pp., $4.00, Paul B. Hoeber, Inc., 1959.

For the past several decades, increasing numbers of people have sought advice from their physicians or genetic counselors on questions dealing with heredity. Perhaps a baby has been born with some defect or disease suspected of being hereditary. Shall the parents risk another child? Perhaps a contemplated marriage involves first cousins, or a family history of some defect. Is the marriage likely to result in defective children? These and many other similar questions are increasingly being asked.

Heredity counseling has developed as part of the overall medical services in a number of medical schools and clinics. Such counseling has come about sporadically, where there happened to be a geneticist whose research interest lay in human heredity, or a physician who was well versed in genetics. Little serious attempt had been made to survey and correlate such counseling practices until the American Eugenics Society sponsored a sym-

(Continued on page 106)



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In back pain, bursitis, sprains, strains, and bruises, whiplash and other traumatic injuries, inflammatory and degenerative muscle and joint complaints.

Many patients report they feel better and sleep better with SOMA than with any previously used analgesic or relaxant drug.

SOMA often makes possible reduction or elimination of steroids, salicylates, sedatives and narcotics.

RAPID ACTING. Pain-relieving and relaxant effects start within 30 minutes and last for at least 6 hours.

NOTABLY SAFE. Toxicity is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy on higher than recommended dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white sugar-coated 350 mg. tablets.

Literature and samples on request.

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(Continued from page 86)

"Two physicians will be paid in cases where the operating surgeon returns the patient to the referring physician for after-care, provided that such transferral is made necessary due to geographical factors or extraordinary extenuating circumstances. Separate billing by each physician is necessary, setting forth the value of each service, the total of which shall not exceed the fee schedule allowance. In such instances, request for separate payments must be submitted in writing to the office of the Medical Director of HMSA."

It was explained that this recommendation had been previously approved by the Board of Governors as part of a report submitted by the Division of Surgical Fee Committee on Itinerant Surgery. However, two changes in the wording of the paragraph have been recommended by the Medical Care Plans Committee, and consequently needs membership approval before it can be incorporated into the HMSA Manual.

Considerable discussion followed on this recommendation. Strong opposition to this paragraph was voiced by the general practitioners. They felt that if a physician has known and taken care of the patient for a number of years, and a surgeon is called in to do the surgical workup, and if the referring physician assists with the surgery and follows up with the post-operative care, then he is entitled to a part of the surgical fee. Also, if you took into consideration the psychological and medical-legal aspects involved, the referring physician justly deserves to be compensated.

It was mentioned at this time that this division of fees is just what we are trying to get away from, and is only permissible under unusual extenuating circumstances.

A motion made by Dr. Millard to change the wording of this paragraph to allow two physicians to be compensated in proportion to the services rendered by the physicians involved, was tabled by Dr. Henry, whose motion to table was seconded and was carried, 29 to 14.

Dr. Henry then moved that the recommendation of the committee be accepted.

Further pro and con discussion followed. Dr. West stated that it was his feeling that this matter boils down to one thing and that is, this regulation deals only with itinerant surgery. Dr. Henry stated that if the membership desires that certain funds be made available for assisting physicians, then other provisions should be made. Perhaps we could take this matter to some committee for consideration.

Before the question was voted on, Dr. Richert reiterated that this paragraph pertained only to itinerant surgery and extenuating circumstances. He also stated that if any member was interested in this particular problem to write to the Fee Adjustment Committee of the Society who will come up with some recommendation and perhaps something could be worked out with HSMA.

ACTION:

Dr. Henry's motion to accept the recommendation of the committee was then voted on and was carried, 37 to 13.

IV. HMSA has recommended that the following sentence be added to paragraph 18 of the "Administrative Instructions and Procedures" which would permit review and verification of claims:

(Continued on page 97)



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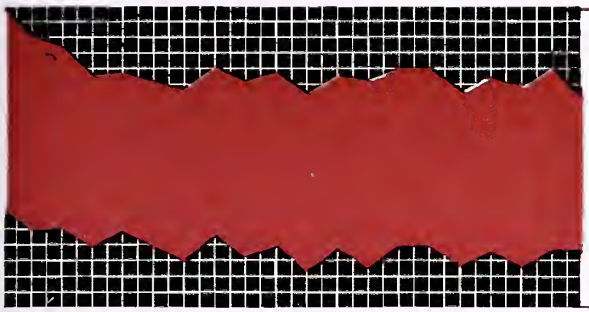
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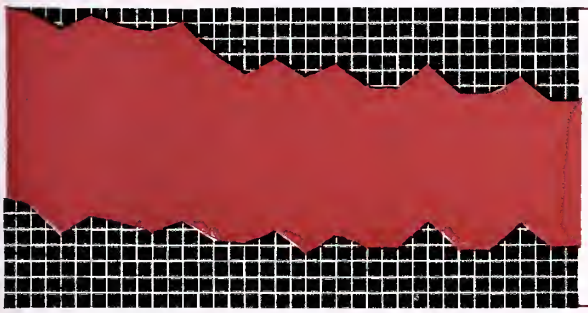
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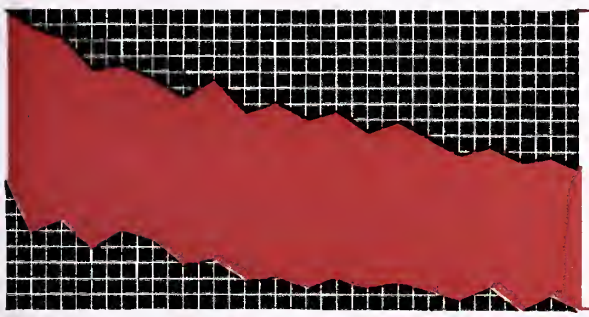
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- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
- Headache, dizziness, palpitations and tachycardia are usually promptly relieved. Anginal pain may be reduced in incidence and severity.
- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

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25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

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If the patient is receiving ganglion blocking drugs or hydralazine, their dosage must be cut in half when HYDROPRES is added.

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with ferric pyrophosphate,
a form of iron
exceptionally
well-tolerated

in taste-tempting cherry flavor

Average dosage, 1 teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	75%

Bottles of 4 and 16 fl. oz.

promote protein uptake

with the
potentiating effect
of l-Lysine on
low-grade
protein foods

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COUNTY SOCIETY REPORTS

(Continued from page 93)

"All claims paid or payable shall be subject to review and verification, including inspection of pertinent records of any physician or hospital."

Dr. Moore stated that it was the committee's feeling that the present wording of paragraph 18 was sufficient to handle the problem and that as a matter of principle this addition should more or less be held in abeyance at this time. The committee felt that under the present wording of the administrative procedure, if a physician refuses examination of his record, HMSA has the right to withhold payments from the doctor if they want additional information. This is a private matter between HMSA and the individual physician. Dr. Moore further stated that the management of HMSA has made one suggestion to their first recommendation; and that is, to add the words "upon authorization of the Medical Committee of HMSA" to the sentence.

A letter from our attorney was read which upheld the change along the lines as suggested by HMSA.

In answer to a question as to why this additional safeguard is needed, Mr. Veltmann stated that in certain specific cases where irregular billings have been disclosed, the physician still remained a participating physician. He stated that even if we withhold payments on claims, we are entitled to recover that which has been paid.

ACTION:

Following further discussion, Dr. West moved that the new sentence be added to paragraph 18 of the Administrative Instructions and Procedures with the addition of the words "upon authorization of

(Continued on page 100)

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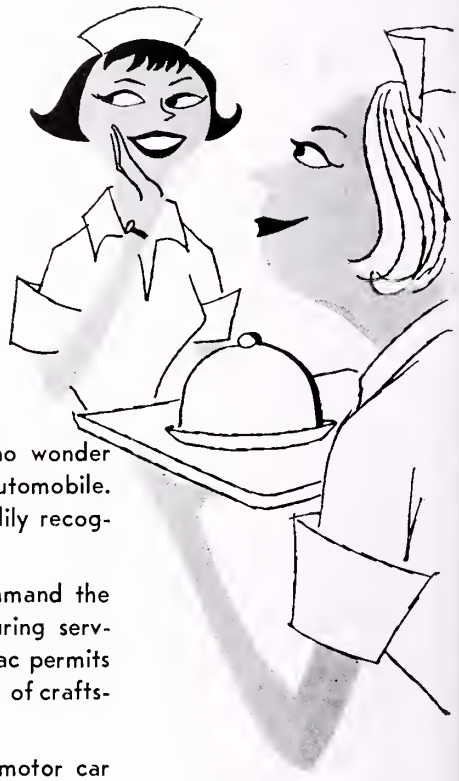
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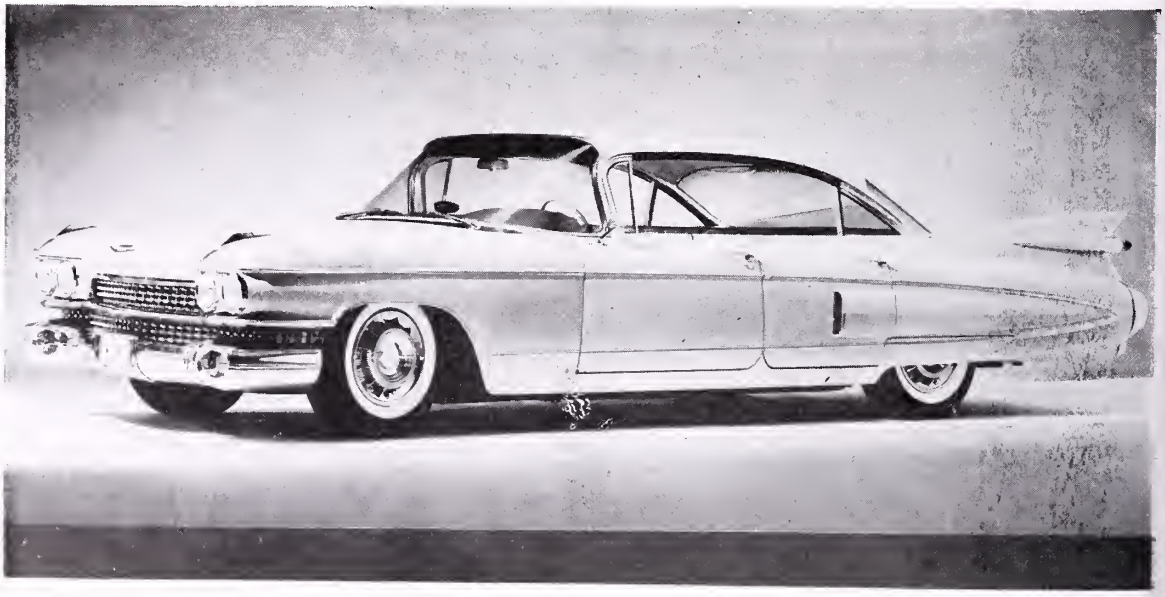


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References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

*Trademark

(Continued from page 97)

the Medical Committee of HMSA." The motion was seconded and was passed.

Social Security for Doctors

Dr. Arnold, Jr. brought out that since this would be the largest gathering of the membership before the AMA meeting in June, he would like to have a show of hands to have him, as their delegate, vote in favor of the referendum to be held for Social Security at the forthcoming meeting. The doctors were unanimously in favor of social security.

Adjournment

Before the meeting was adjourned, Mr. Kennedy brought out again that he wanted the members to be aware of what they voted on with regard to Recommendation III. He reiterated that although it was true that this section applies to itinerant surgery only, it was also true that the *only* time there can be a division of the surgical fee is when a patient is returned to the referring physician due to geographical factors or extraordinary extenuating circumstances. Mr. Kennedy went on to say ,"I am sure that many of you here tonight are not aware of what you have passed, and because I have to sit in the society office and answer the many inquiries regarding misunderstandings of the membership's proceedings, I want you all to be aware that by what you have passed here tonight, you may only divide the surgical fee under two circumstances and that is due to geographical factors or under extraordinary extenuating circumstances. You cannot do it at any other time."

The meeting was adjourned.

* * *

Dr. T. H. Richert presided at the May 5 meeting and approximately 125 members and guests were present.

An enjoyable and learned discussion on the "Status of Steroids After Ten Years" was presented by Dr. Philip S. Hench of the Mayo Clinic who is a Nobel Prize Winner for his work on cortisone. A Question and Answer Period followed.

Dr. Beverly Jeanne Burdette and Dr. Wallace Loui were welcomed into the Society as new members.

Dr. Quisenberry introduced to the members some new staff members of the Health Department who were connected with the new Virus Laboratory located out at Hale Mohalu. He stated that Dr. Max Levine; Dr. Gordon Wallace, Consultant in Comparative Medicine in Public Health and Dr. Robert Kissling, on loan from the U. S. Public Health Service, are all helping to get the virus laboratory started.

Dr. Leabert Fernandez, chairman of the Legislative Committee, brought the membership up to date on the committee's recent activties in the Legislature. He brought out that at the end of the session it was quite evident that the committee had failed in many respects to produce effectively and the main reason seemed to be the lack of consideration of the legislator for the medical man. He stated that the time has come when the average doctor has to take a more active interest in politics and he was here tonight to get some suggestions from the membership as to how the Legislative Committee can go about getting better legislation for the doctors.

Dr. Frissell brought out a glaring example of how things went in the Legislature when a certain bill was passed requiring the presence of an optician in the ophthalmologist's office when the physician was fitting a patient with contact lenses. The reason, he stated, for this bill being passed was because the optometrists outnumbered the physicians and did a better job of lobbying. He also stated that if the Medical Society wants certain legislation passed for the good of public health, then it will have to re-organize its Legislative Committee to become more potent, and the individual members themselves will have to give more of their time to legislative matters.

Dr. Fernandez further stated that one of the biggest difficulties was their not knowing what was going on within the Legislature, and that it won't be easy to find out what they want to know unless the Society has one of its own members working actively in the Legislature.

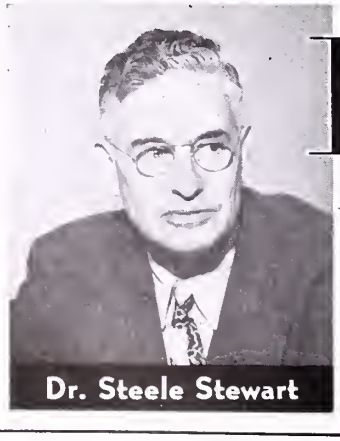
It was mentioned that Dr. Corboy and Mr. Kennedy were planning to run for the State Legislature.

A discussion followed regarded what assistance the Society could give to its members who may decide to run for office.

Dr. Hartwell moved that the Board of Governors be empowered to do whatever it can to help a member of the Society who decides to become a candidate for office. The motion was seconded.

Mr. Kennedy brought out that in order not to jeopardize the eleemosynary status of the Society, the Society could hire an employee to assist the candidate with secretarial work at the expense of the Society, or hire a full time lobbyist or have the Executive Secretary go down as a full time lobbyist and hire an assistant to take his place.

(Continued on page 104)



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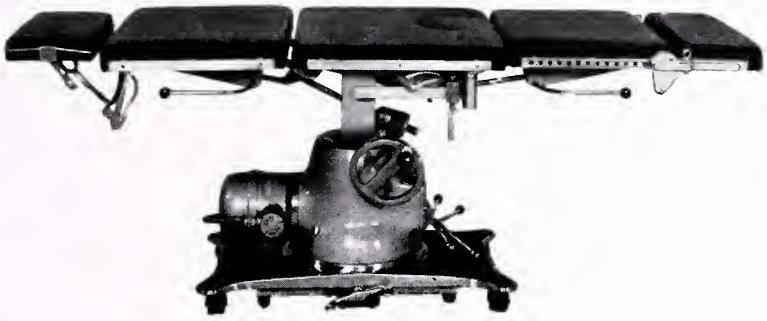
WARNING: **Don't permit your widow to drink this draught alone. Share its memory with her.**

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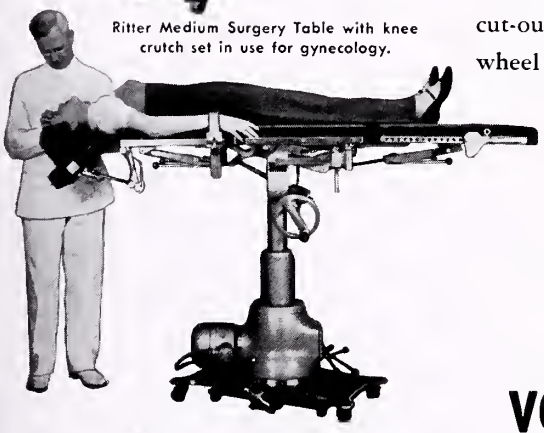
The motor-elevated Medium Surgery Table moves quietly, smoothly from 26½″ to a maximum of 44½″ with effortless ease.

Standard equipment includes adjustable headrest, perineal cut-out, irrigation pan, adjustable kneerest, stirrups, and hand wheel operated tilt mechanism. In addition, optional equipment not illustrated includes armrest, ether screen, shoulder supports and cushions for Sims position in proctologic work.

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"VULVOVAGINITIS, CAUSED BY TRICHOMONAS VAGINALIS, CANDIDA ALBICANS, Haemophilus vaginalis, or other bacteria, is still the commonest gynecologic office problem . . . cases of chronic or mixed infection are often extremely difficult to cure." Among 75 patients with vulvovaginitis caused by one or more of these pathogens, TRICOFURON IMPROVED cleared symptoms in 70; virtually all were severe, chronic infections which had persisted despite previous therapy with other agents. "Permanent cure by both laboratory and clinical criteria was achieved in 56. . . . "

Ensey, J. E.: Am. J. Obst. 77:155, 1959

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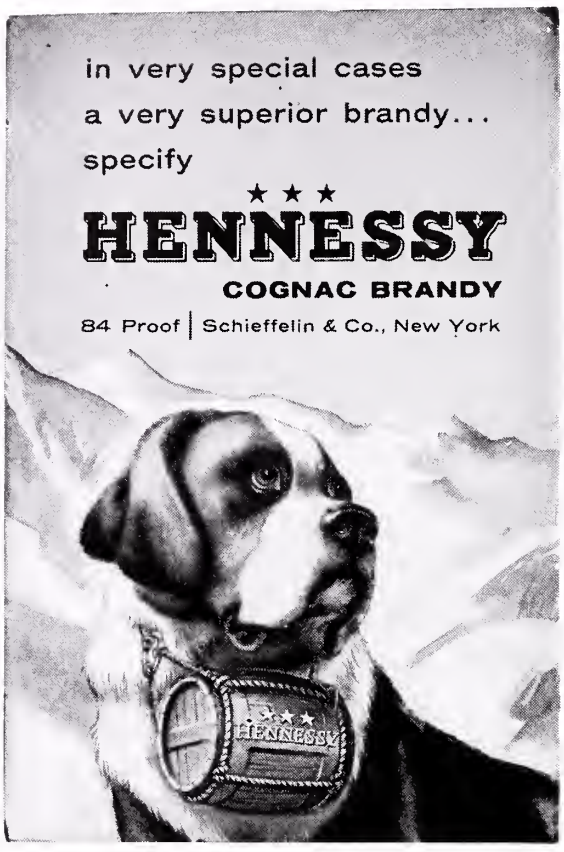
1. POWDER for weekly insufflation in your office. MICOFUR®, brand of nifuroxime, 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

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COUNTY SOCIETY REPORTS

(Continued from page 100)

Several members voiced objections to Dr. Hartwell's motion stating that there would be members from both parties running and who was going to decide which candidate the Society should support. It was also mentioned that the Society is a non-political organization and would be criticized for supporting any one candidate. It was felt that any support from the Society should be for the support of legislative matters and not for individual candidates.

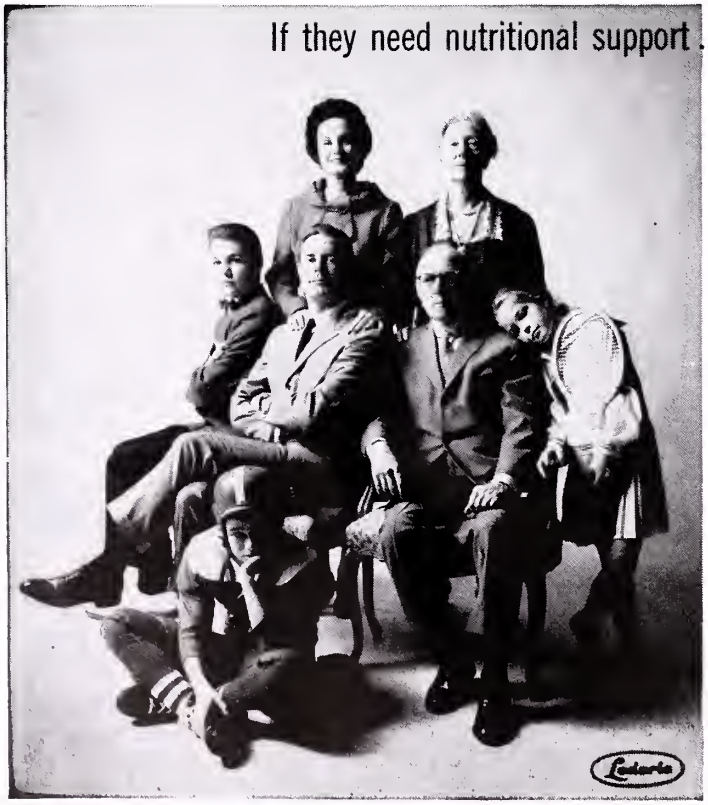
A motion to table Dr. Hartwell's motion was made by Dr. deHay which was seconded and was passed.

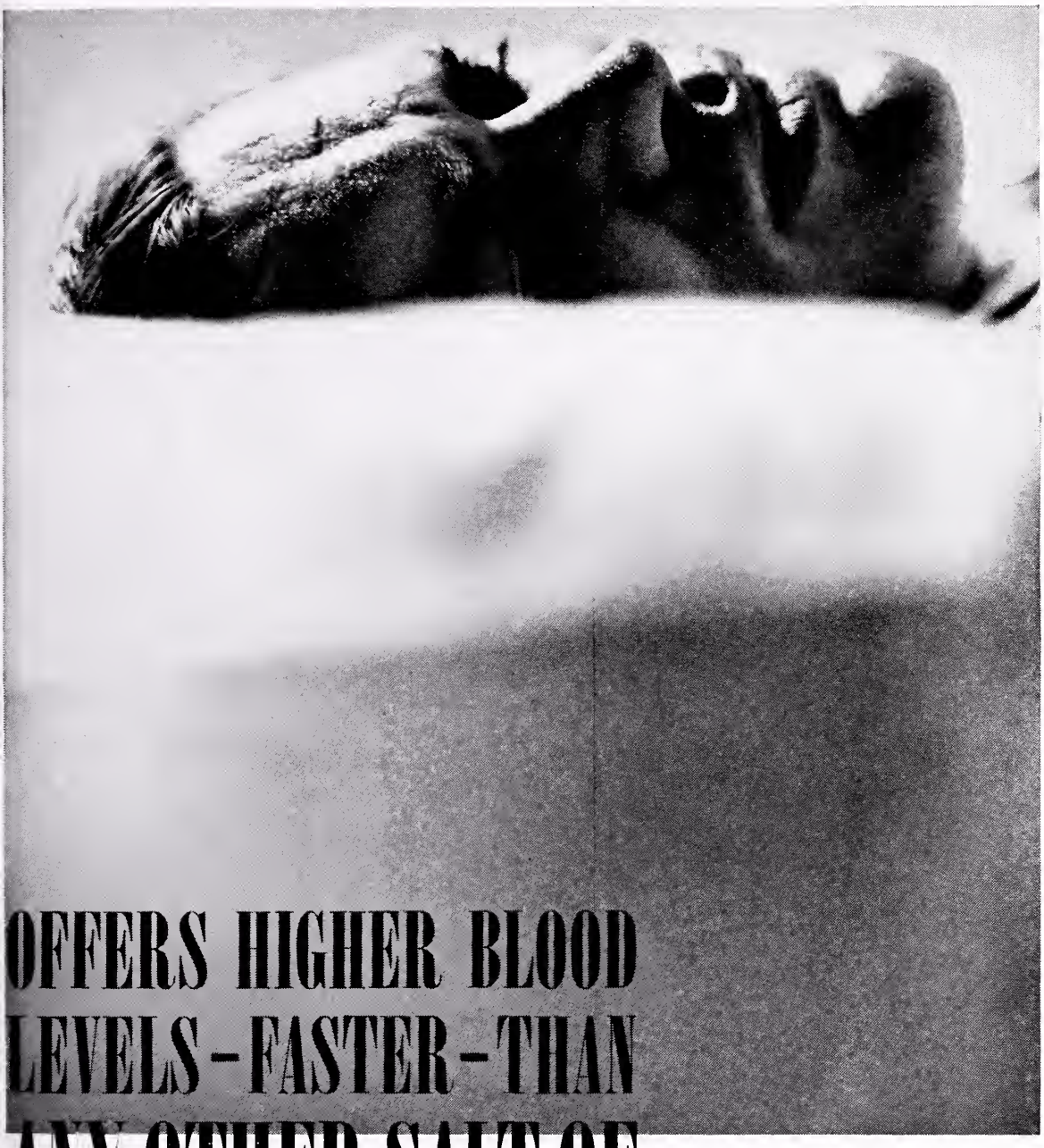
A vote of thanks was given to Dr. Theodore Tomita for his help in this past legislature and a motion to transmit to Mrs. Dorothy Devereux our appreciation for her efforts in the Society's behalf was made by Dr. Glover.

Dr. Richert brought out that Dr. Kawasaki's Emergency Medical Service Committee is having difficulty in staffing Kaiser's Hospital in case of an emergency or practice drill, as the doctors are not too happy about being assigned there.

Dr. Nishigaya urged that the doctors cooperate with the committee in every way, as the committee has worked long and hard to get things organized, and by refusing to accept their assignments would only tend to hamper the committee's operations. The doctors, he stated, should accept their assignments with the idea that it is for the good of the entire population.

A. S. HARTWELL, M.D.
Secretary





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(Continued from page 90)

posium on the subject. This volume is the result of that symposium.

The ten papers presented at the meeting form the first ten chapters of the book, the eleventh chapter consisting of several discussions of the papers. The presentations discuss principles rather than specific facts. Types of problems brought to the counselor, avenues of referral, the structure of heredity clinics, the training and competence of counselors, the general types of advice given to clients, the question of fees, the use of empirical risk figures, and the legal and ethical aspects of counseling, are all well discussed. It is to be hoped that the book will interest more and more young physicians and medical students in preparing themselves carefully for a service which is rapidly becoming indispensable in medicine.

LAURENCE H. SNYDER, Sc.D.

Also Received

★Antibiotics Annual 1958-1959

Edited by Henry Welch, Ph.D., and Felix Marti-Ibanez, M.D., 1107 pages, $12.00, Medical Encyclopedia, Inc., 1959.

Almost 200 articles and two panel discussions from the sixth Annual Symposium on Antibiotics, held last October in Washington. An invaluable reference.



The Medical Clinics of North America, Vol. 43, No. 3

Marion B. Sulzberger, M.D., Guest Editor, pp. 633-968, W. B. Saunders Company, May, 1959.

A New York symposium on diseases of the skin.

Pediatric Clinics of North America, Vol. 6, No. 2

James B. Arey, M.D., Consulting Editor, pp. 339-654, W. B. Saunders Company, May, 1959.

A symposium on neoplastic diseases in early life.

Science and Psychoanalysis, Vol. 11

By Jules H. Masserman, M.D., 218 pages, $6.75, Grune & Stratton, 1959.

For psychiatrists only. Part I is about masochism, Part II about family dynamics.

Practical Notes on Nursing Procedure

By Jessie D. Britten, S.R.N., 196 pages, $4.00, Williams & Wilkins Co., 1959.

A practical manual, somewhat marred for use in the U.S.A. by British spelling and British technical terms and trade names.

Surgery in World War II, Vol. 1

Editor-in-chief: Col. John Boyd Coates, Jr., MC, 467 pages, $5.00, Office of the Surgeon General, Dept. of the Army, Wash. D.C., 1958.

For neurosurgeons, of course. Primarily of military and historical interest.

Now or Never

By Smiley Blanton, M.D., 273 pages, $4.95, Prentice-Hall, Inc., 1959.

An experienced counsellor offers some sane advice about making the most out of "middle age." Very readable.

★The Family Medical Encyclopedia

By Justus J. Schiffers, 617 pages, $4.95, Little, Brown & Co., 1959.

A practical and—from a cursory examination—sound home reference work for the layman. "Caduceus" is sadly misdefined, but in medical matters there seem to be very few errors, none of them serious.

Biosynthesis of Terpenes and Sterols

By G. E. W. Wolstenholme, E.B.E., M.A., B.Ch., Maeve O'Connor, B.A., 311 pages, $8.75, Little, Brown and Co., 1959.

All about mevalonic acid and isoprene biosynthesis.

The Symptom as Communication in Schizophrenia

Editor: Lt. Col. Kenneth L. Artiss, MC, 233 pages, $5.75, Grune & Stratton, 1959.

Military psychiatry offers a thought-provoking idea about early schizophrenia.

★Treatment of Diabetes Mellitus, 10th Ed.

By Joslin, Root, White, Marble, 798 pages, $16.50, Lea & Febiger, 1959.

The tenth edition in 43 years—a standard text in its first revision since 1952.

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NIAMID is clinically effective in a broad ran depressive states, including: involutional m cholia, senile depression, postpartum depres reactive depression, the depressive stage of m depressive disease, and schizophrenic depre reaction.

A wide variety of psychoneurotic depressions in general practice also respond effectivel NIAMID. Depression associated with the menop and with postoperative states, and depressio companying chronic or incurable diseases suc gastrointestinal and cardiovascular disorders thritis, and inoperable cancer, can now be tre successfully with NIAMID.

NIAMID is also strikingly effective for many plaints, mild or severe, vague or well defined, due to masked depression rather than to or disease. This masked depression may take the of guilt feelings, crying spells or sadness, diffi in concentration, loss of energy or drive, inson emotional fatigue, feelings of hopelessness or lessness, loss of interest in normal activity, lis ness, apprehension or agitation, and loss of app and weight.

While tranquilizers have had some measu effectiveness in many of these areas, NIAMID gives the practicing physician a new, safe dru the specific treatment of depression without risk of increasing the depressive symptoms.

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Acute and chronic toxicity studies show this tinctive freedom from toxicity. Moreover, d the extensive clinical trials of NIAMID by a number of investigators, not only has no liver age been reported, but only in a very few iso instances have hypotensive effects been seen.

The absence of toxicity may be the result o unique carboxamide group in the NIAMID mole This structure may explain why NIAMID is exc largely unchanged in the urine, with only insi cant quantities of potentially free hydrazine formed. Previously, where a monoamine ox inhibitor had been associated with hepatic tox there was some evidence that substantial quan of free hydrazine were formed in the body.

Background of NIAMID

A major advance in the treatment of menta pression came with a newer understanding influence of brain serotonin and norepinephri the mood. Levels of both these neuro-hormon decreased in animals under experimental tions analogous to depression; relief of these depressions is seen with a rise in the levels o serotonin and norepinephrine.

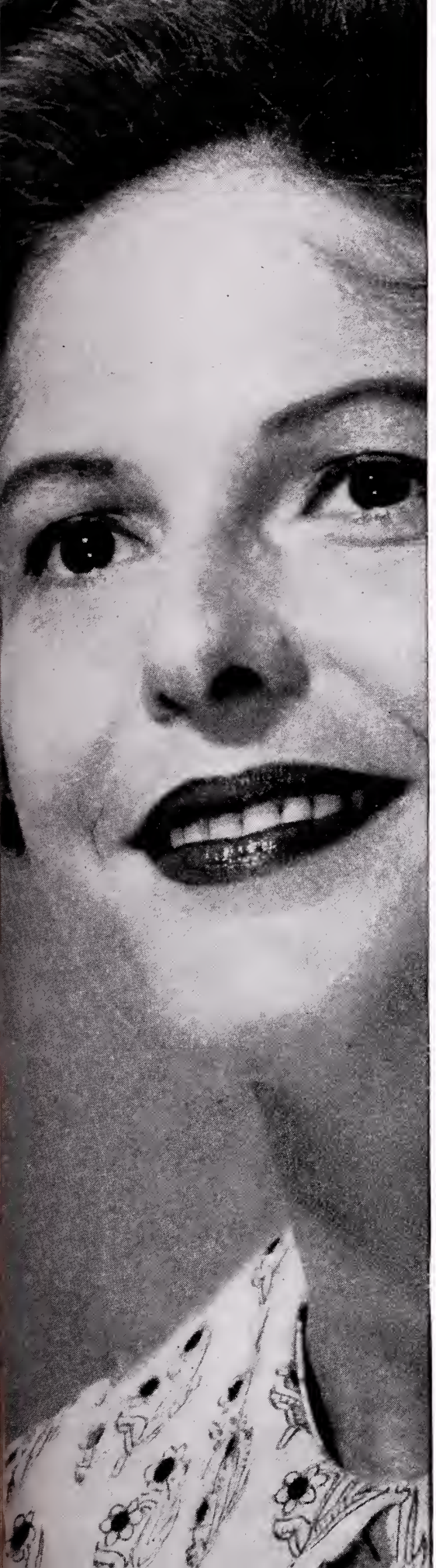
A second advance came with the developm monoamine oxidase inhibitors, substances raise the cerebral level of both serotonin an epinephrine. The first of the amine oxidase i tors raised the cerebral level of serotonin, b not appear to raise that of norepinephrine proportionately.

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Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

Complete bibliography and Professional Information Booklet are available on request.

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new hope for fetal salvage

DELA

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein[1] in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann.[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

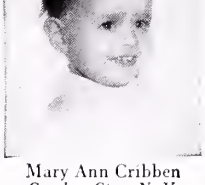
64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that in Delalutin-treated women, fetal salvage of infants below term weight (1000 to 2000 gm.) was significar improved. 108 (76%) of 142 babies of t birth weight survived without mothers rec ing progestational therapy, while 16 (100 of 16 babies of this birth weight survived w mothers receiving Delalutin therapy. A c parison study was made of a group repeated aborters treated with Delalu and a group with a similar history trea with bed rest and sedation.[4] Pregna salvage with Delalutin was twice that of control group. Delalutin was found to "highly active", well-tolerated and lo acting.

According to Tyler and Olson,[5] "Th qualities of prolonged action and relat freedom from local reactions ma [Delalutin] a generally more desira therapeutic agent for intramuscular than progesterone . . . ."

DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL ABOR



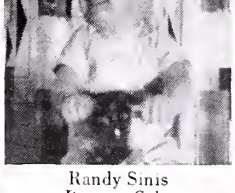
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Garden City, N. Y.



Amy Sue Greenman
Lincolnwood, Ill.



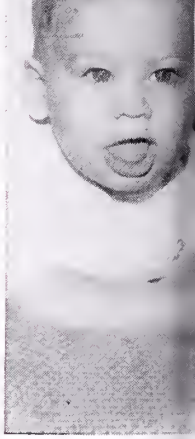
William Peller
Skokie, Ill.



Randy Sinis
Denver, Colo.



Richard Miller
Denver, Colo.



Scott Knudse
Norwich, Vt

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 1959.

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improved progestational therapy

BB HYDROPROGESTERONE CAPROATE

LALUTIN offers these advantages over other progestational agents:

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

ALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated genital malignancy; infertility with inadequate corpus luteum function; production of tory endometrium and desquamation during estrogen therapy; premenstrual tension; enorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

inistration and dosage:

use of its low viscosity, Delalutin may be admin-ed with a small gauge needle (deep intragluteal tion). Complete information on administration dosage is supplied in the package insert.

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these healthy, normal babies was born by a mother with a documented previous history habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



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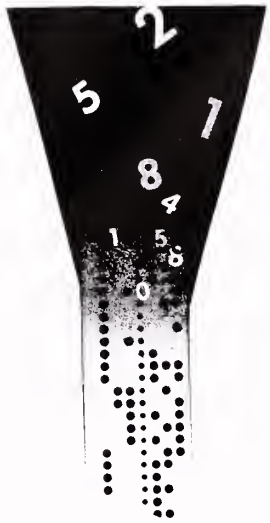
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CORRESPONDENCE

(Continued from page 5)

involved. We would be pleased to cooperate in such a study. As your editorial now stands it generates more heat than light. You do have a responsibility to elucidate issues of this importance and which touch on the lives of many millions of people.

WILLIAM S. CLARK, M.D.
Director of Medical Care

Aug. 10, 1959

We are in agreement with Dr. Clark, apparently, on certain points:

1. Polio eradication is the principal mission of the National Foundation.

2. This has not been accomplished.

3. It is difficult to reply to the criticisms contained in the editorial.

4. It is the right and the responsibility of the JOURNAL *to elucidate issues of this importance.*

In answer to the specific question, the "we" in the editorial is the Editor. The State Association has not yet taken any position in the matter.

We had hoped, and still do, that some explanation of the National Foundation's reasons for its "new look," other than those suggested in the editorial, might be forthcoming.

We hope that readers who disagree with the editorial or agree with it, will be willing to write us a note to say so.—ED.



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For arthritic M.S.: full corticosteroid benefits from new Gammacorten[T.M.]



Patient M.S., 81, at the time of the first visit was in severe pain and very uncomfortable. Complained of swelling of wrists, legs and various joints; pain and stiffness in cervical area and lower spine; pain, swelling and limited motion in the fingers; slight ulnar deviation of the hand. M.S. demonstrates position necessary to put on his hat (motion was so restricted that he could not comb his hair).

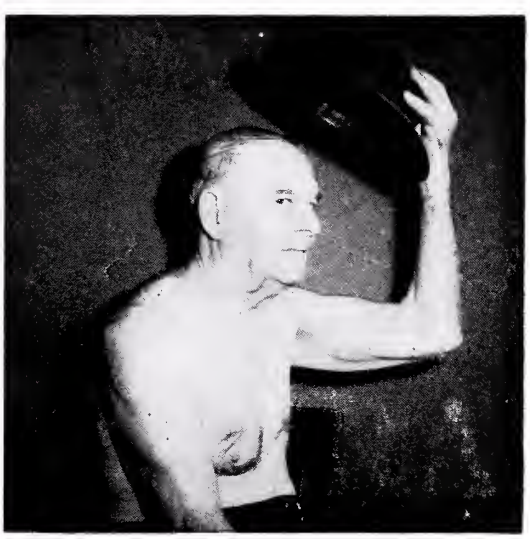
Treatment and Result: After 36 hours of GAMMACORTEN therapy, M.S. had "complete relief." Joint swelling had decreased, pain was almost absent, range of motion had increased dramatically. At the end of the first week of GAMMACORTEN he was free of discomfort and able to return to his job as a porter. M.S. could put on his hat normally, could comb hair; joint function near-normal after first week.

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1. Editorial, New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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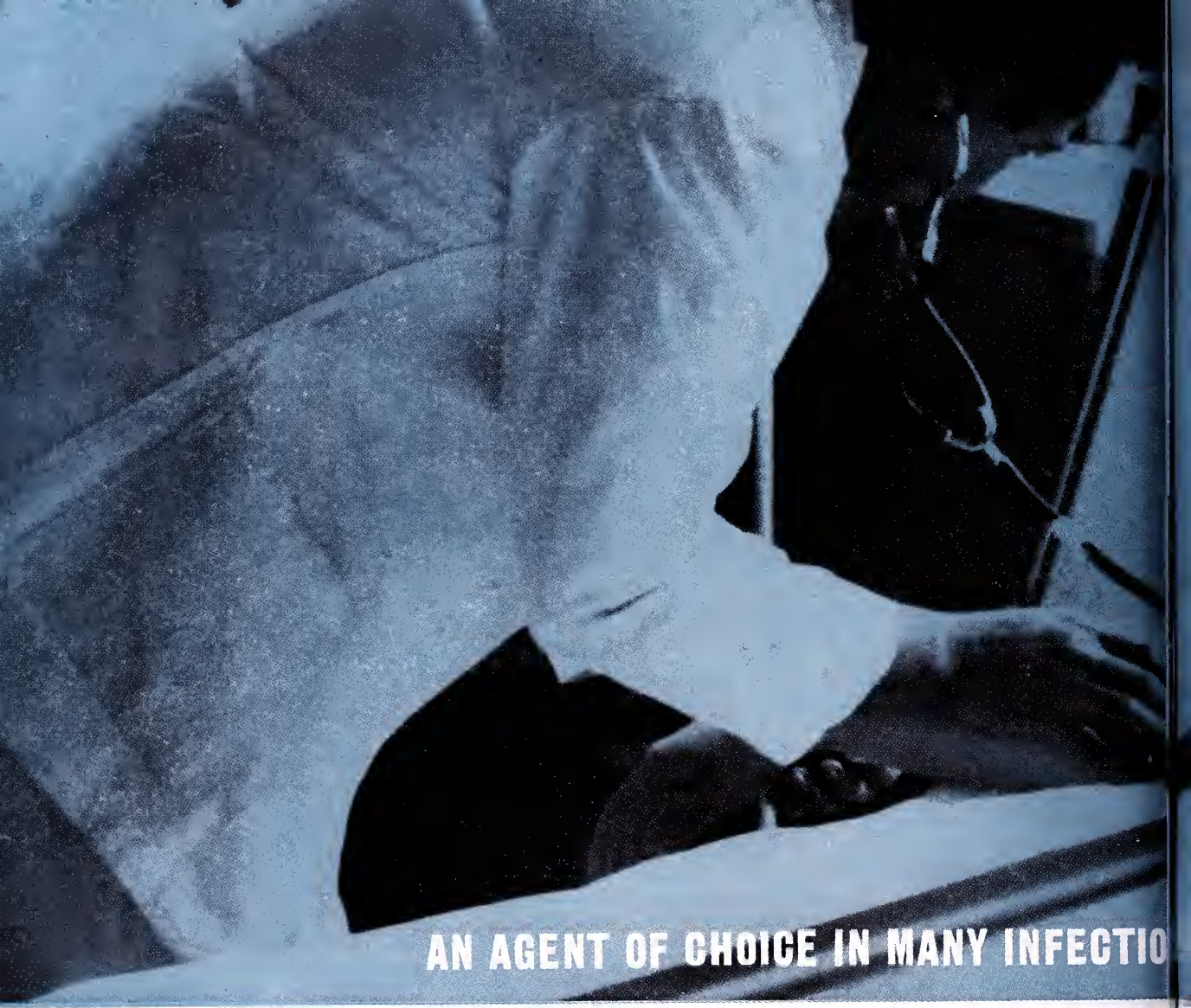


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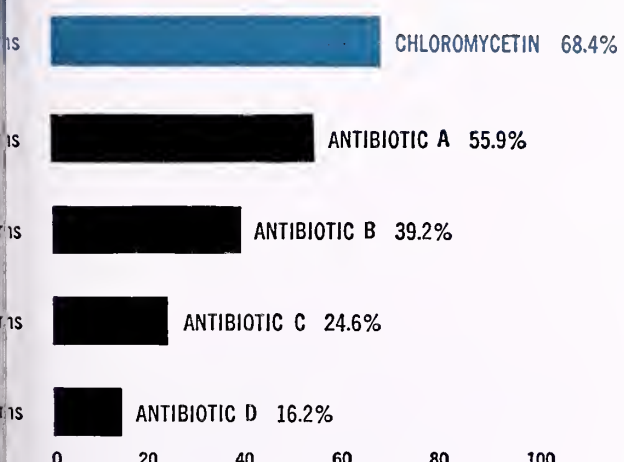
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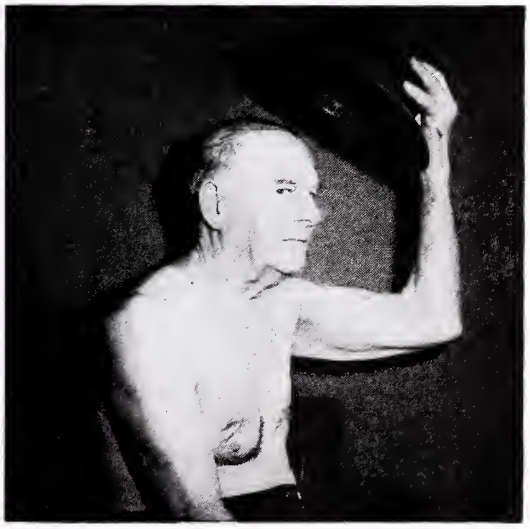
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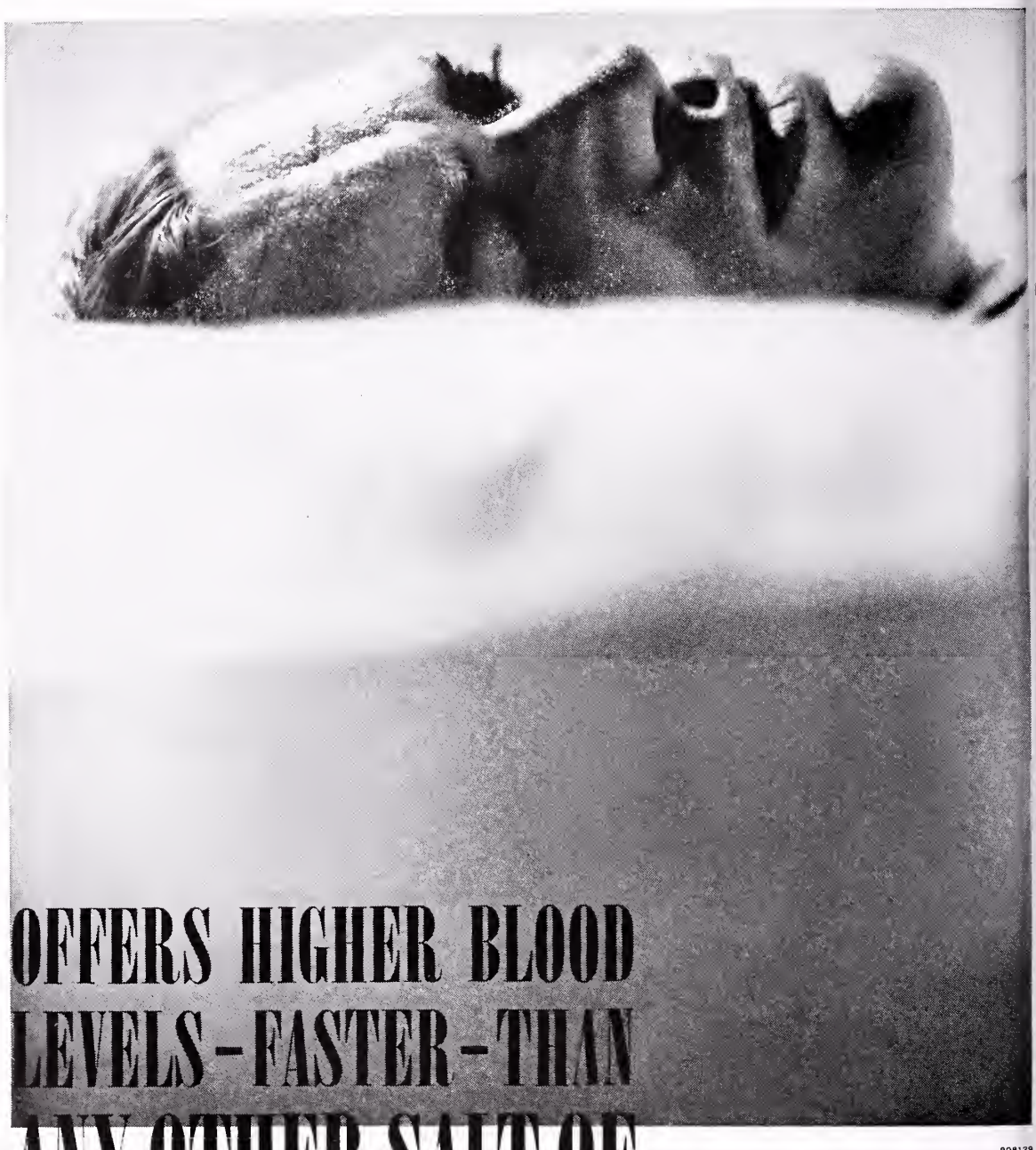
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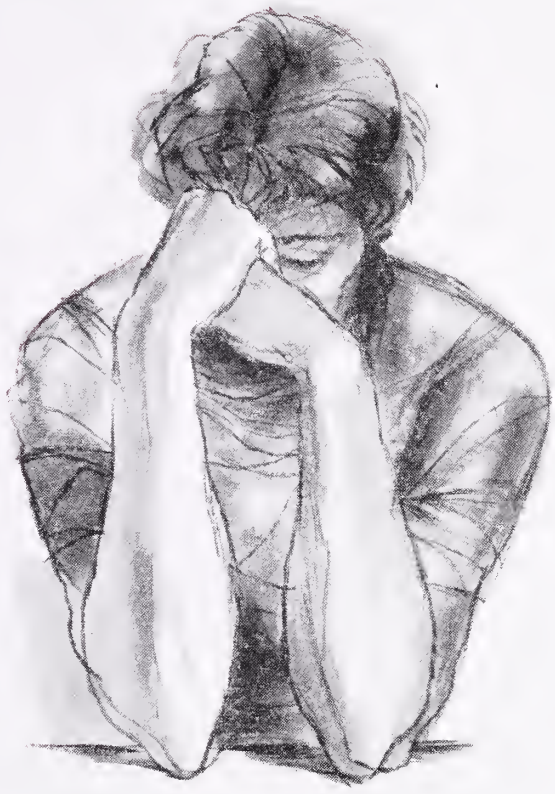
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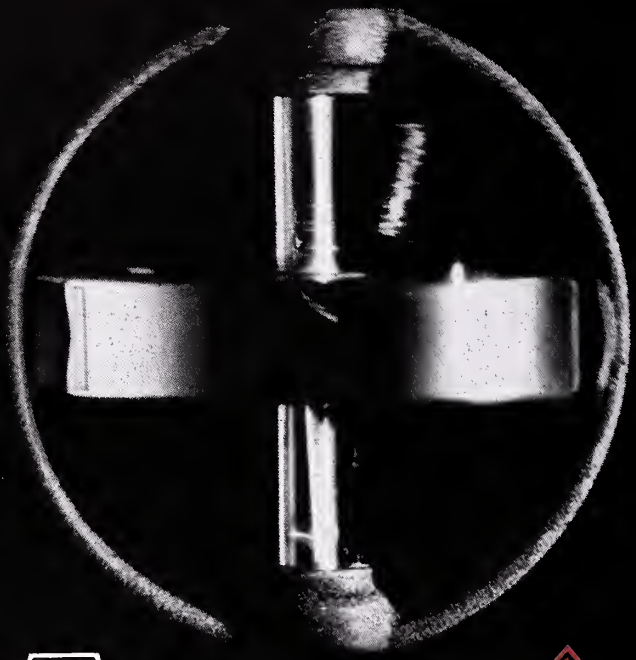
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References: 1. Feinberg, S.M., Feinberg, A.R., and Fisherman, E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sherwood, H.: *Connecticut Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S. and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North East M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 1958. 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:710 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Freyberg, R.H.; Berntsen, C.A., and Hellman, L.: *Arthritis and Rheumatism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Pract.* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gantner, G.E.: *Ann. Rheum. Dis.* 17:398 (Dec.) 1958. 13. Appel, B.; Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:648 (Sept.) 1958. 16. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M.: *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.A.* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leake, D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:720 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:257 (Jan. 17) 1959. 20. Rein, C.R.; Fleischmajer, R., and Rosenthal, A.R.: *J.A.M.A.* 165:1821 (Dec. 7) 1957.

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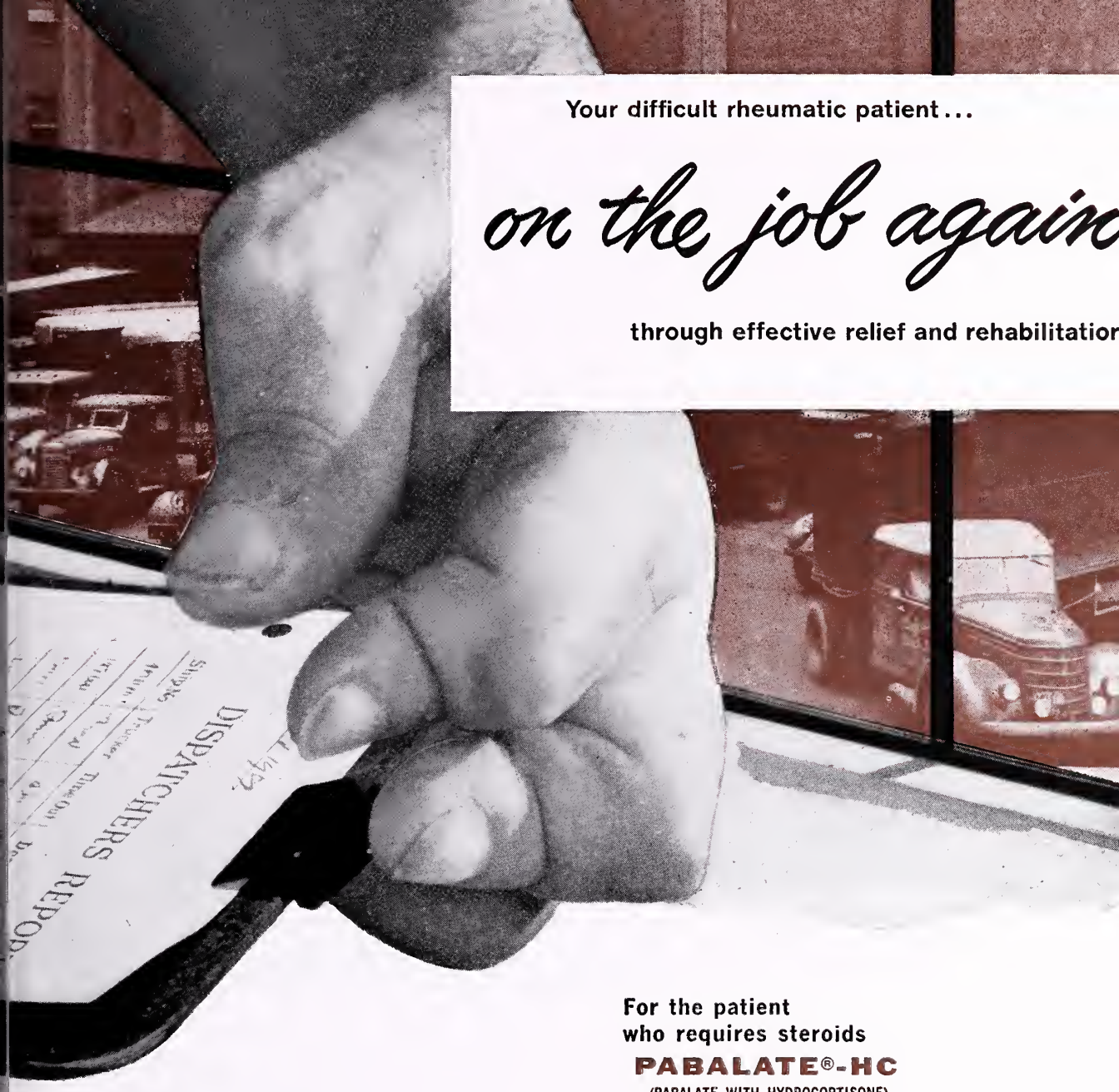


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REFERENCES: 1. Editorial: J.M.A. Georgia **46**:433, 1957. 2. Colby, F. H.: Essential Urology, Baltimore, The Williams & Wilkins Co., 1953, p. 330.

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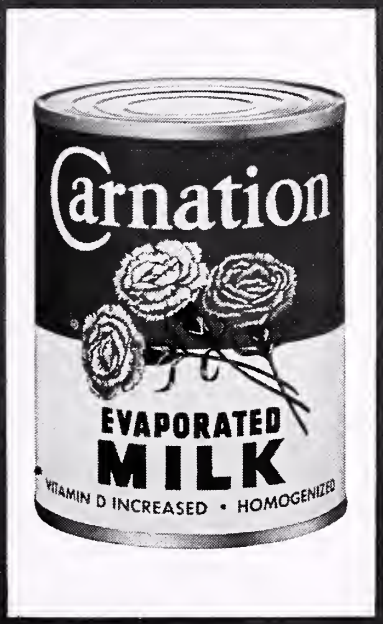
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*Rost, Edward J., and Todd, Wilbert R., Textbook of Biochemistry, 2nd Ed. (New York, Macmillan, 1955), p. 522; p. 1074-5.

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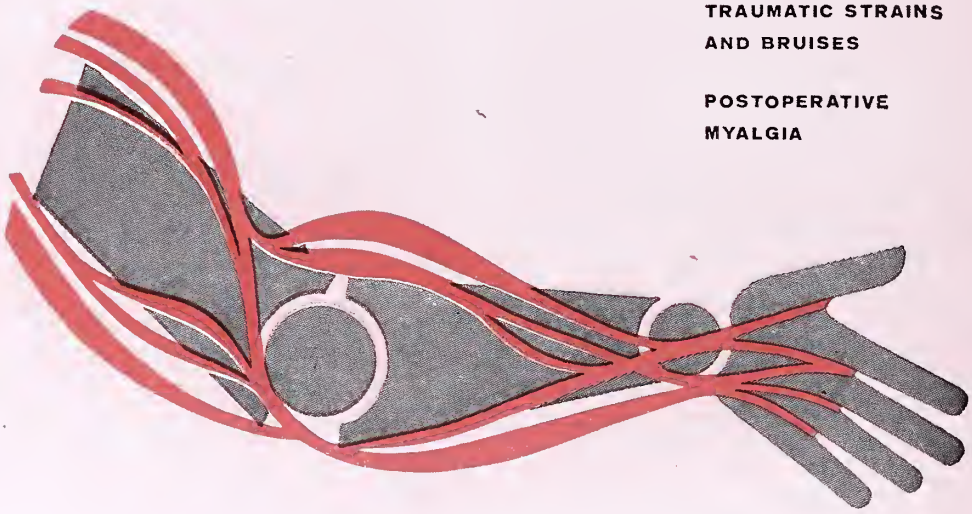


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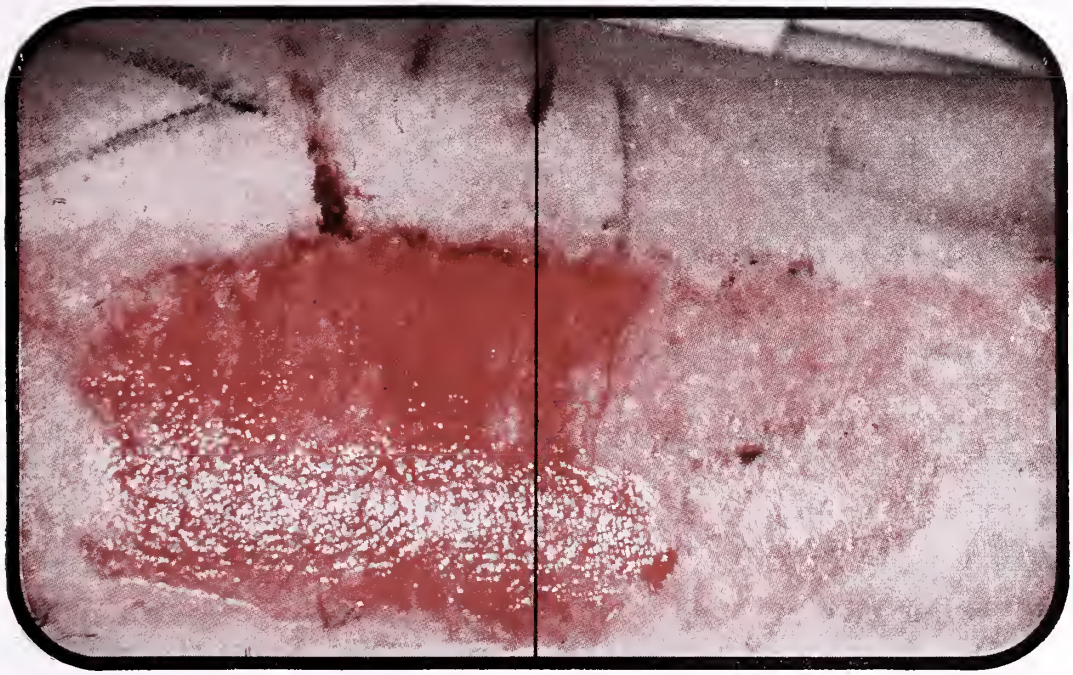
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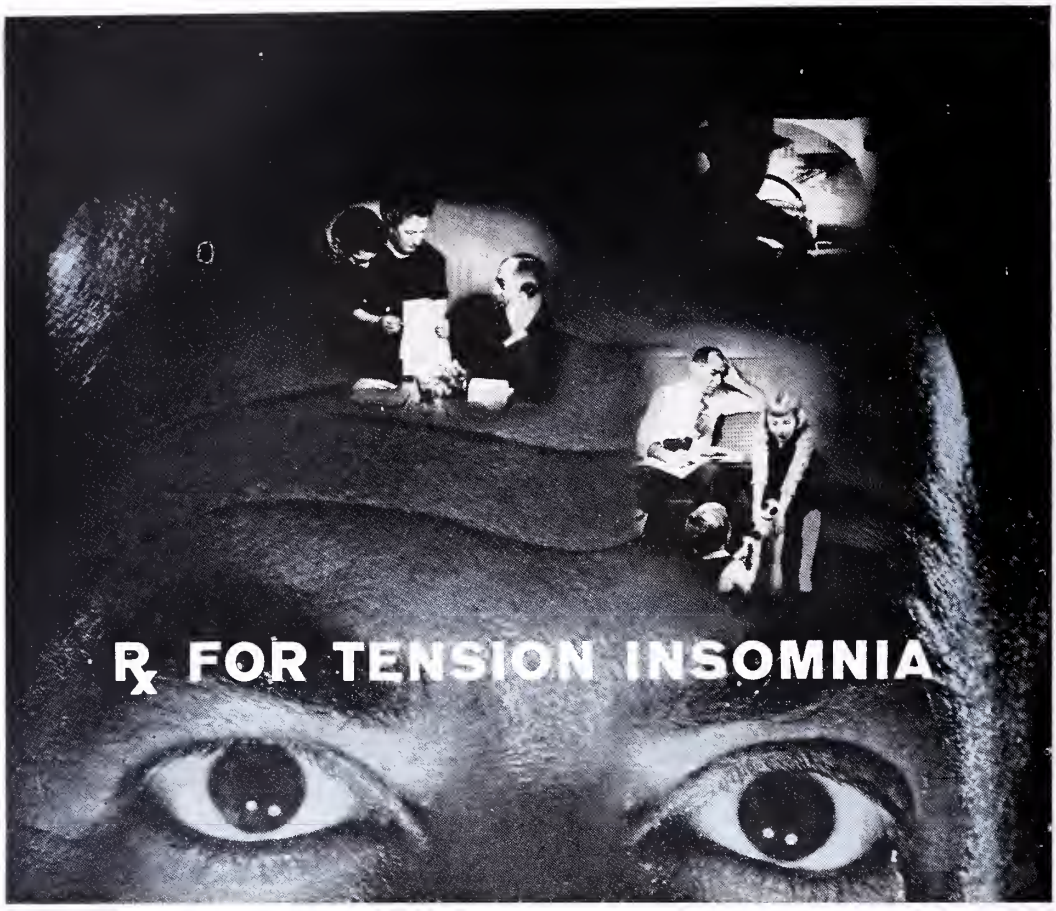
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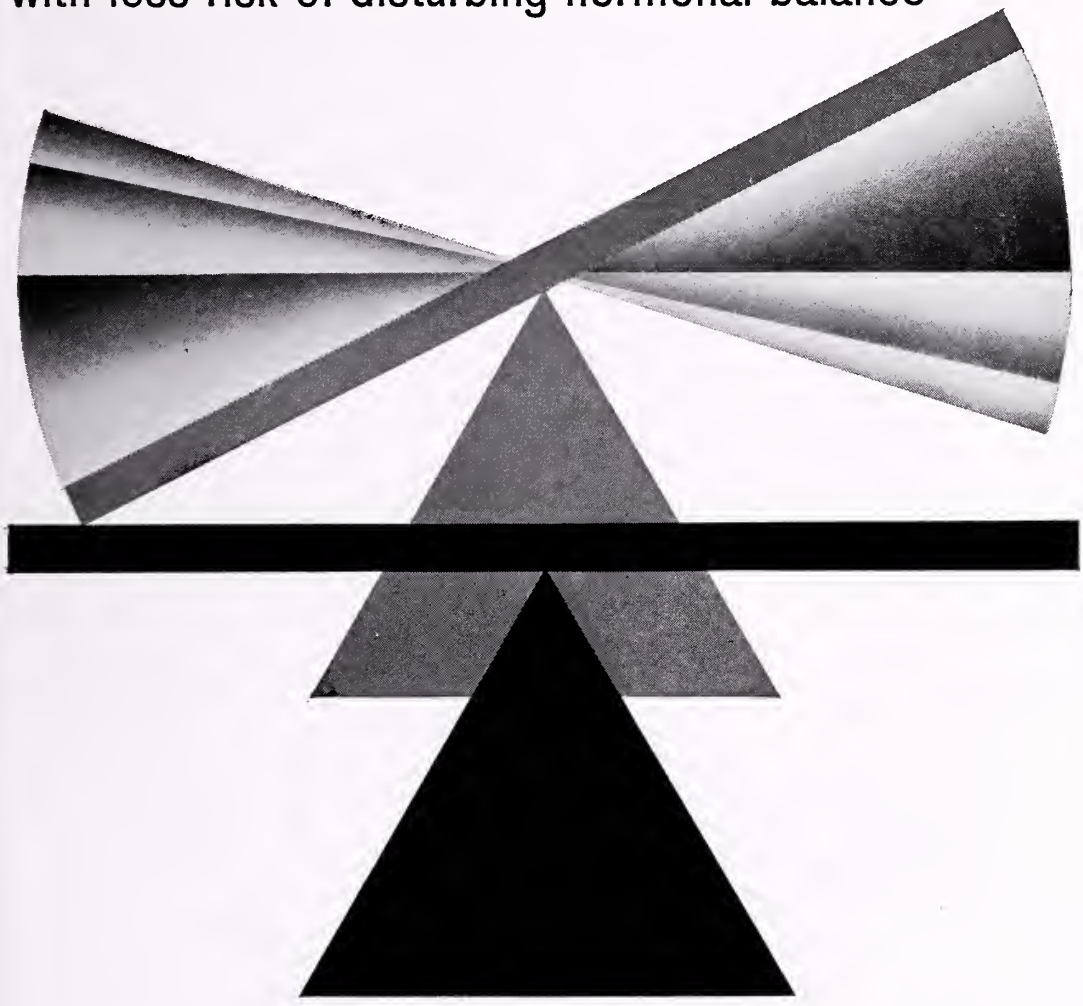
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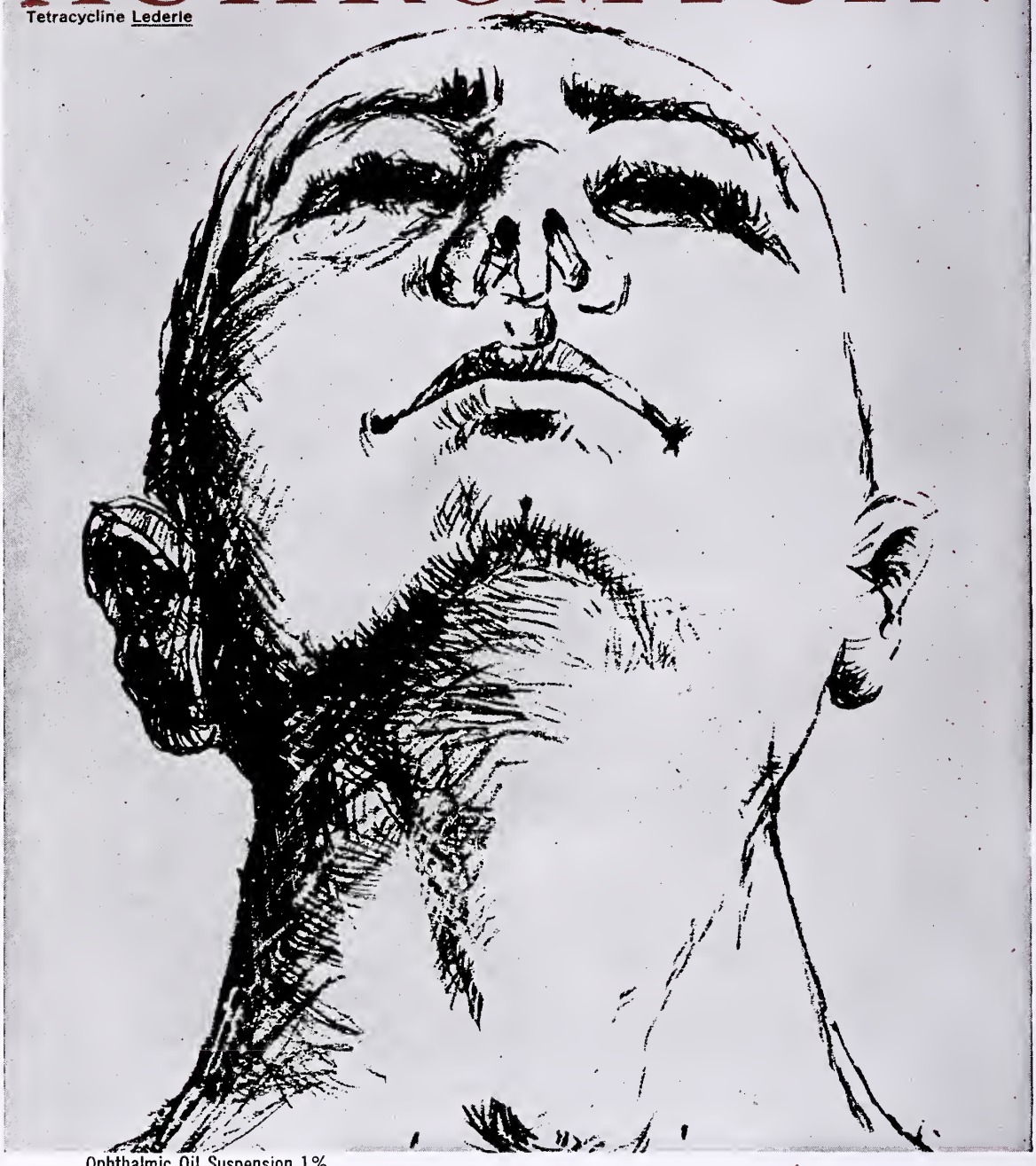
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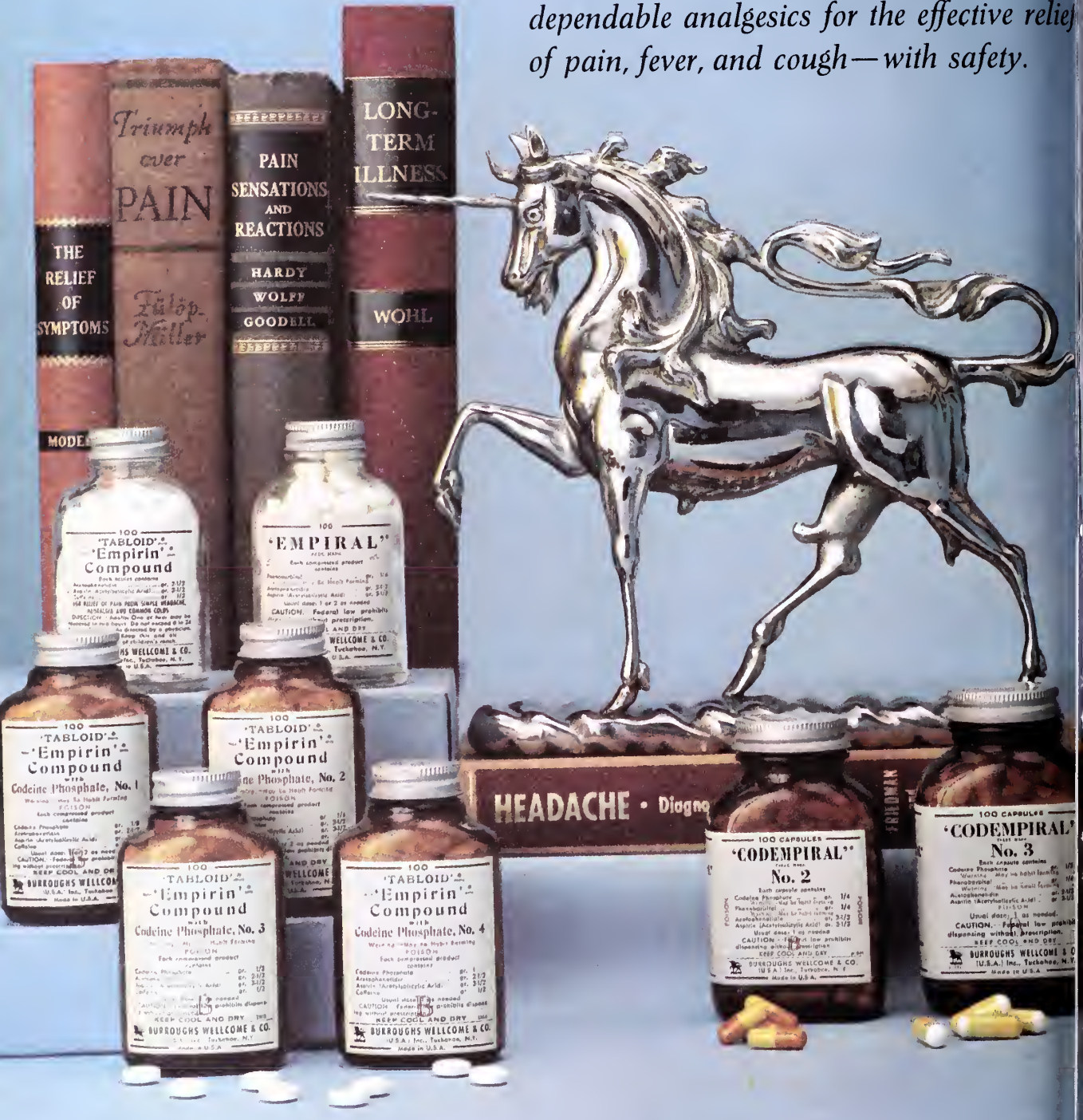
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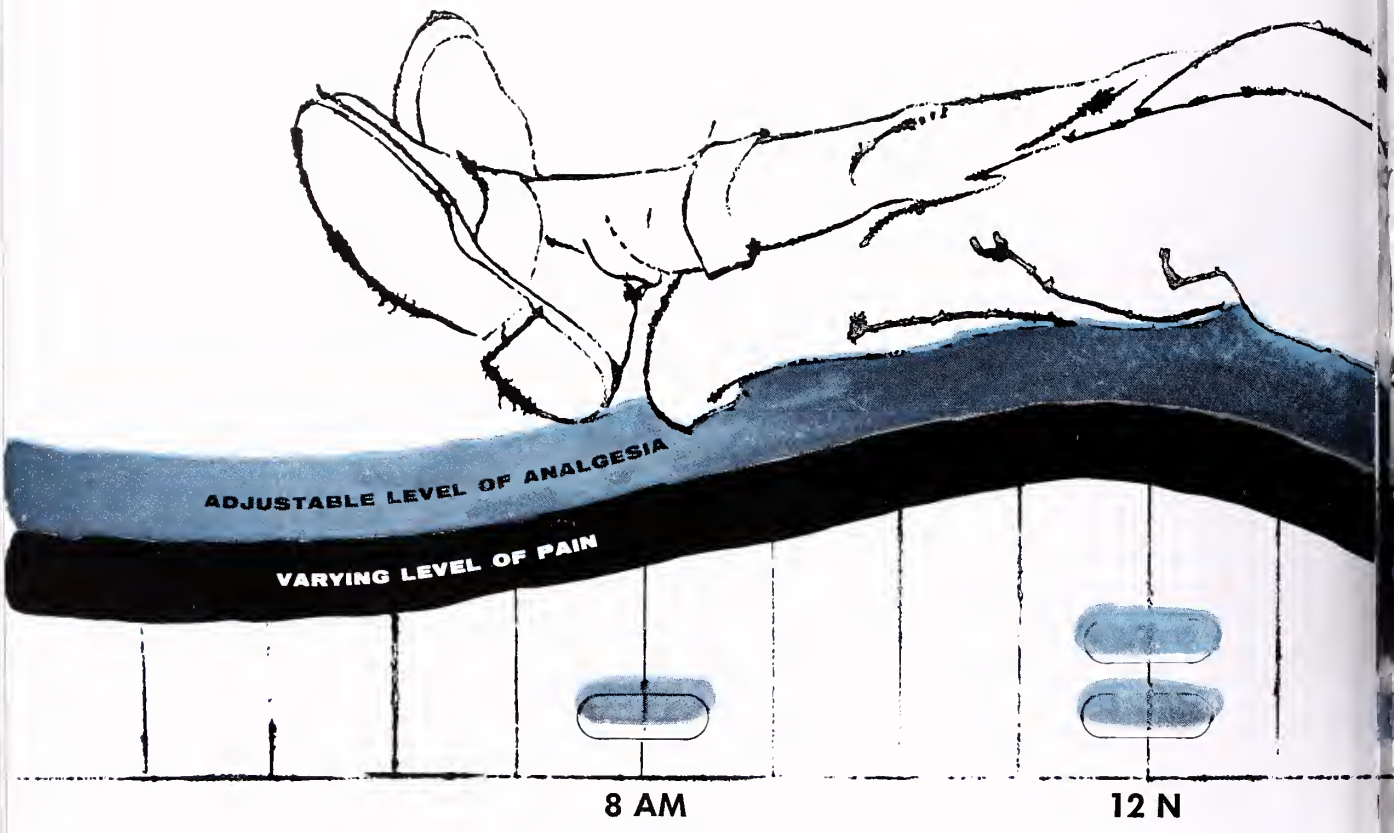
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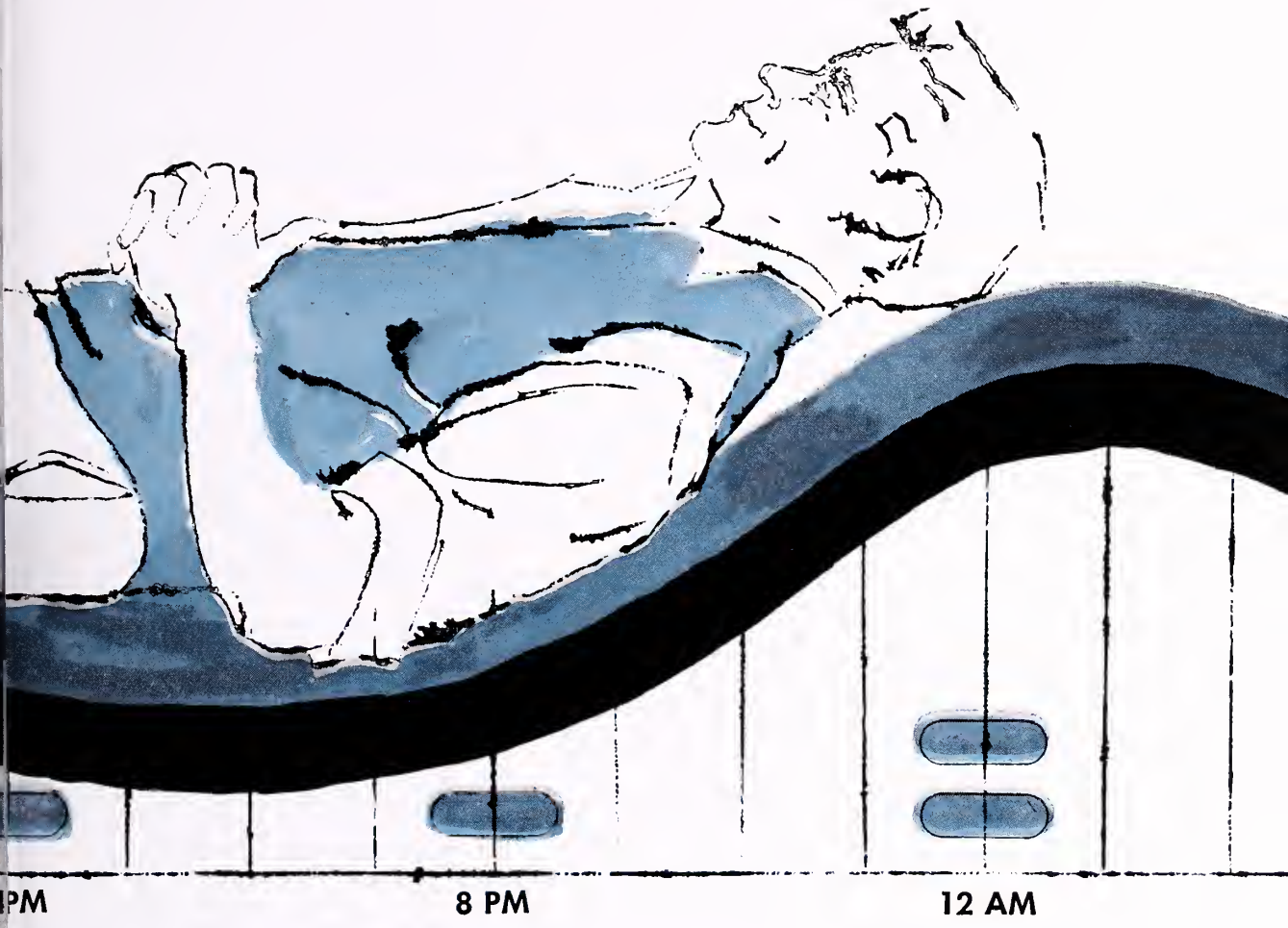
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Serum Lipoprotein Studies Among Nisei* in Hawaii

KYURO OKAZAKI, M.D., Honolulu

SINCE ANCEL KEYS reported his studies on serum cholesterol on Italian subjects in Naples in 1954,[1] similar studies have been done elsewhere—Keys, Bronte-Stewart, and Larsen[2] in Minneapolis, Honolulu, and Japan; Bronte-Stewart in South Africa, Brozek in Yugoslavia, and more recently Brunner[3] in Israel. They all point to the fact that a high animal fat diet is one of the major factors in producing human atherosclerosis and coronary heart disease. Atherosclerosis is caused by derangement of cholesterol metabolism[4] in human body. Water insoluble cholesterol does not circulate in human serum as such, but in combination with phosphorus as phospholipid[5] and with other lipid and protein as lipoprotein molecules. Whether atherosclerosis is caused by changing of total cholesterol and phospholipid ratio or by increasing B/a lipoprotein ratio or by increasing Standard Sf 0-12 and Standard Sf 12-400 classes of lipoprotein, it is the qualitative and quantitative alteration of lipoprotein in human serum that is responsible for atherogenesis.

Gofman, using the ultracentrifuge of Svedberg, separates serum lipoprotein into four distinct classes—Standard Sf 0-12, Standard Sf 12-20, Standard Sf 20-100, and Standard Sf 100-400. Since Standard Sf 12-20 behaves like Standard Sf 0-12 and Standard Sf 20-100 behaves like Standard Sf 100-400, he groups them into two main classes —Standard Sf 0-12 and Standard Sf 12-400. Standard Sf 0-12 is increased by ingestion of large quantities of animal and saturated fats and lowered by decreasing them. Standard Sf 12-400 is influenced by carbohydrate, and animal fat has no effect on this lipoprotein. Most atherosclerosis is caused by elevation of Standard Sf 0-12 class, but some is caused by derangement of carbohydrate metabolism with subsequent rise in Standard Sf 12-400 class. It is very important from the standpoint of therapy to know that a few cases of atherosclerosis are caused by starchy foods.[6]



DR. OKAZAKI

After analyzing several thousand cases of human serum, Glazier devised mean lipoprotein levels for Standard Sf 0-12 and Standard Sf 12-400.

* American-born Japanese, of Japan-born parents.

Read before the 103d annual meeting of the Hawaii Medical Association, Hilo, April 25, 1959.

[1] Keys, A., Fidanza, F., Scardi, V., Bergami, G., Keys, M., and Lorenzo, F.: Studies on serum cholesterol and other characteristics of clinically healthy men in Naples, A.M.A. Arch. Int. Med. 93:328-336 (March) 1954.

[2] Keys, A., Kimura, N., Kusukawa, A., Bronte-Stewart, B., Larsen, N. P., and Keys, M. H.: Lesson from serum cholesterol studies in Japan, Hawaii and Los Angeles, Ann. Int. Med. 48:83-94 (Jan.) 1958.

[3] Brunner, D., Lohl, K.: Serum cholesterol, electrophoretic lipid pattern, diet, and coronary artery disease, Ann. Int. Med. 49:732-750 (Oct.) 1958.

[4] Stamler, J.: Pathogenesis and therapy of atherosclerosis, Med. Clin. North America 35:177-194 (Jan.) 1952.

[5] Moses, C.: The prevention of atherosclerosis, Postgraduate Med. 15: 467-471 (May) 1954.

[6] Lipoprotein studies with respect to coronary heart disease, Monograph No. III, The Institute of Medical Physics.

TABLE 1. *Mean Lipoprotein Levels in mg %*

	MEAN AGE	STANDARD SF 0-12	STANDARD SF 12-400
Males:	4.3	312	132
	16.2	264	131
	25.0	302	178
	35.1	340	236
	44.2	364	260
	54.1	367	257
	61.1	360	239
Females:	5.0	290	129
	16.9	271	105
	23.5	283	107
	35.2	304	143
	44.0	346	187
	53.9	363	240
	61.5	369	301

Source: Glazier et al, "Human Serum Lipoprotein Concentrations."

The Mean Standard Sf 0-12 level for men at age 35 corresponds to similar value for women at age 44. Man's at age 44 corresponds to woman's at age of 54. In other words, woman has the advantage of 10 years over man. A 35-year-old man is already 44 years old and a 44-year-old man is already 54 years old when compared with serum lipoprotein of a woman of corresponding age. Recently, Barr, Furman, Robinson, and Hagino studied the effects of female sex hormone upon the lipoprotein[7] and found that estrogen definitely confers immunity to women during their productive life against atherosclerosis and coronary heart disease with few exceptions such as in diabetes, nephrosis, hypothyroidism, and in familial xanthomatosis.

Gofman and his associates, at the Donner Laboratory of the University of California, devised a simple means by which atherogenicity of Standard Sf 0-12 and Standard Sf 12-400 is calculated as the Atherogenic Index[9] (A.I.).

$$\text{A.I.} = \frac{\text{Standard Sf 0-12} + 1.75\ (\text{Standard Sf 12-400})}{10}$$

The A.I. is far from perfect, but when used with lipoprotein analysis, it indicates readily and fairly accurately the degree of atherosclerosis. According to them, a man whose A.I. is 75 or less is so unlikely to develop coronary heart disease that no treatment is needed; a man with A.I. of 75 to 100 has a higher than average chance of developing coronary heart disease, and he should be placed on dietary restriction;[10] if a man's A.I. is over 100, his chance of developing coronary heart disease is definitely above average and it is imperative that he be placed under a strict dietary program.

[7] Robinson, R., Cohen, W., and Hagino, N.: Estrogen replacement therapy in women with coronary atherosclerosis, Ann. Int. Med. 48: 95-101 (Jan.) 1958. Robinson, et al.[8]

[8] Robinson, R., Hagino, N., and Cohen, W.: The effect of estrogen on serum lipids of women, Arch. Int. Med. 100:739-743 (Nov.) 1957.

[9] The present status of agents useful in lowering serum lipoprotein levels, Monograph No. 5, The Institute of Medical Physics.

[10] Gofman, J. W., Nicholas, A. V., Dobbin, E. V.: Dietary prevention and treatment of heart disease, 1958.

During the past several months, I studied serum lipoprotein values of about 40 clinically healthy nisei men whose ages ranged from 44 to 59 years, with few exceptions. Due to the expenses involved, my studies were limited to a small number of professional and business men whose economic and social status are above average, but fats are so abundant even in lower economic groups that I believe this study gives a fairly good look at the cross section of nisei population.

In this group, Mean Standard Sf 0-12 was 448 mg per cent while the normal is 367 mg per cent. Mean Standard Sf 12-400 was 304 mg per cent while the normal is 257 mg per cent. There were only eight (29 per cent) whose A.I. was below 75. There were eleven (40 per cent) whose A.I. was above 100. The remaining 31 per cent had A.I. between 75 to 100. Few had very high Standard Sf 12-400 while their Standard Sf 0-12 was normal. The coronary group showed highly ele-

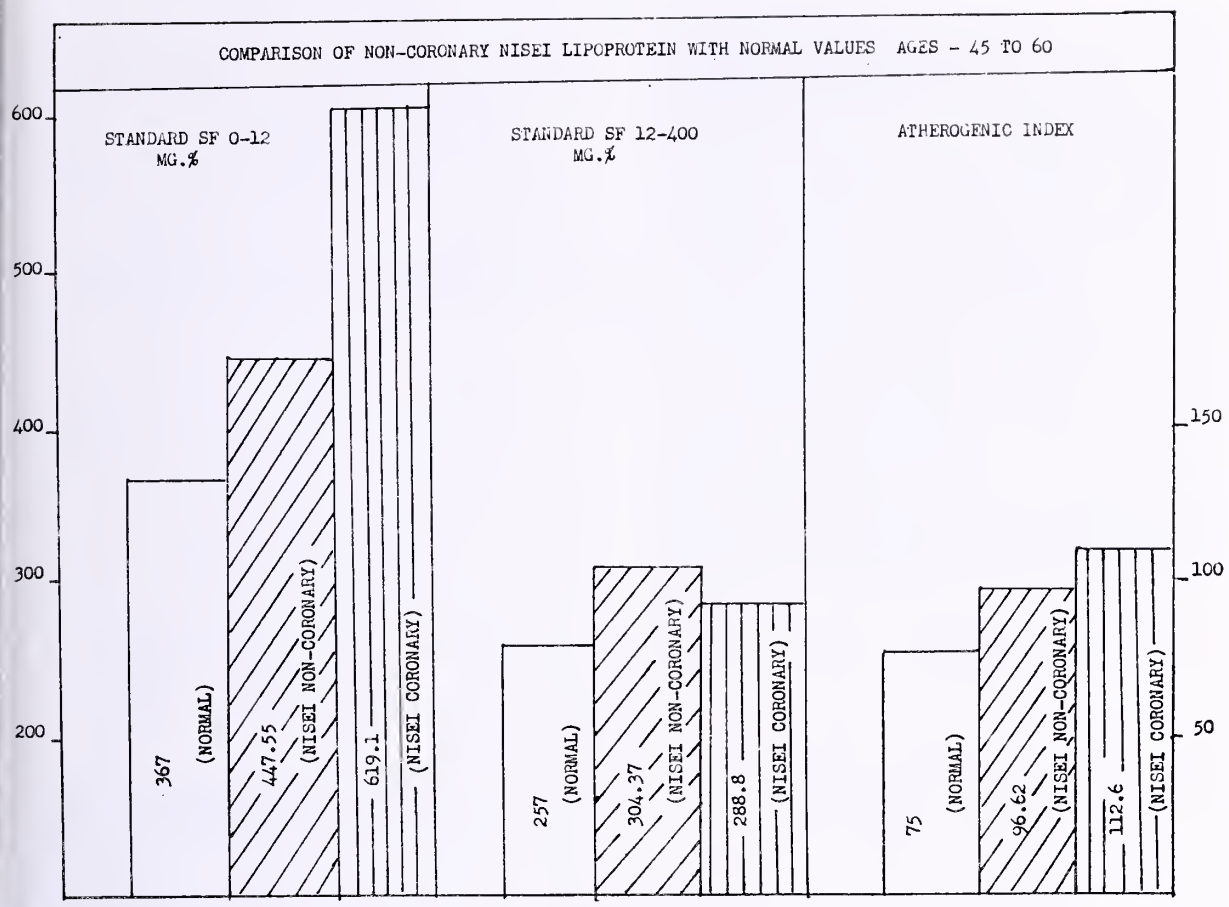
TABLE 2. *Lipoprotein Studies of Nisei*

(NON-CORONARY)

AGE	STANDARD SF 0-12 MG %	STANDARD SF 12-400 MG %	ATHEROGENIC INDEX
52	300	716	155
49	348	612	142
53	495	537	143
48	475	486	130
44	644	233	105
57	670	341	127
55	435	202	79
49	402	241	82
59	370	230	77
58	414	180	73
45	566	112	76
54	383	300	90
53	345	319	90
54	344	195	69
55	435	380	110
52	595	369	124
55	546	326	112
58	457	468	98
53	294	106	48
55	410	110	60
57	481	127	70
59	545	96	71
54	458	275	94
52	498	315	105
58	314	226	71
33	495	505	138
51	329	211	70
Mean	448	304	97

(CORONARY)

AGE	STANDARD SF 0-12 MG %	STANDARD SF 12-400 MG %	ATHEROGENIC INDEX
34	880	273	136
43	711	422	145
38	557	211	93
53	550	369	120
55	522	265	99
54	495	193	83
Mean	619	289	113



vated Standard Sf 0-12 class. Mean coronary Standard Sf 0-12 was 619 mg per cent which is very much higher than mean noncoronary of 448 mg per cent and almost twice as high as the normal of 367 mg per cent. A.I. for coronary group was 112 against a noncoronary index of 96. Gofman and others proved definitely that elevation of serum lipoprotein always precedes coronary accident and such lipoprotein elevation is not the result of infarction. As these studies illustrate, over 40 per cent of niseis show such alarmingly high lipoprotein values that unless something is done immediately, there will be many coronary casualties among them in the very near future. The best way to remedy such a catastrophe is to prevent atherosclerosis by proper dieting. Proper dieting is unsatisfactory unless all the types of lipoproteins are analyzed by ultracentrifuge.

There are three things to be considered in dietary management:[10]

1. If Standard Sf 0-12 is high and Standard Sf 12-400 is normal, as many cases of atherosclerosis and coronary heart disease show, animal or saturated fats should be limited to 25 to 30 grams per day. Protein is kept between 80 and 100 grams. Since Standard Sf 12-400 is normal, no limitation on carbohydrate is needed. Calories lost by restriction of animal fats should be replaced by vegetable oils such as corn oil, cottonseed oil, sunflower seed oil, olive oil, peanut oil, and soy oil. Vegetable oil is unsaturated and has no effect on Standard Sf 0-12 group.

2. If Standard Sf 0-12 is normal and Standard Sf 12-400 is elevated, carbohydrate is limited to 125 to 150 grams per day. Since Standard Sf 0-12 is normal, no animal fat restriction is needed here. Again calories lost must be supplied by vegetable oils.

3. If both Standard Sf 0-12 and Standard Sf 12-400 are increased, reduction of both animal fat and carbohydrate should be advised. Animal fat should not exceed 30 grams and carbohydrate should not exceed 150 grams per day. Eighty to 100 grams of protein should be given and calories lost by restriction of fat and carbohydrate should be supplied by vegetable oils and protein.

If all atherosclerosis cases are treated the same way, by simply reducing animal fats and replacing calories lost by increasing carbohydrate,[9] serum cholesterol will be reduced; but in a few in which Standard Sf 12-400 is high, as shown previously, atherosclerosis will be increased in spite of lowered serum cholesterol because Standard Sf 0-12 carries 34 per cent of cholesterol and Standard Sf



FIG. 1.—Lipoproteins, Standard Sf 0-12 class, under electron microscope, 69,000 times their actual size in human serum. Larger spheres are "yardstick" molecules of known dimension. (*By permission of Dr. Gofman.*)

12-400 carries only 13 per cent of cholesterol. This is one reason why serum cholesterol determination alone is insufficient, compared to lipoprotein analysis by ultracentrifuge.

Another point to be remembered in dietary management is that coconut oil, though vegetable in origin, is saturated and acts like animal fat. All marine oil or fish oil is unsaturated like vegetable oil so that it can be used freely. Hydrogenation converts unsaturated oil to saturated, therefore hydrogenated fats should be classed as animal fat. Some vegetable oils, because of high content of essential fatty acids, may even lower various lipoproteins and aid in prevention of atherosclerosis.

Summario in Interlingua

Le separation ultracentrifugal de lipoproteinas seral secundo le methodo de Gofman monstra que masculos japonese del secunde generation in Hawai, i.e. le nisei, ha anormalmente alte nivellos sanguinee de Sf 0-12 standard, specialmente si illos ha habite symptomas de morbo coronari. Le indice atherogenic del subjectos sin morbo coronari in iste gruppo esseva 96,62, del subjectos con morbo coronari 122,6. Le nivello normal es 75. Pro le prevention de atherosclerotic morbo coronari in iste gruppo ethnic, le autor consilia un meticulose therapia dietari regulate per studios periodic del lipoproteinas seral.

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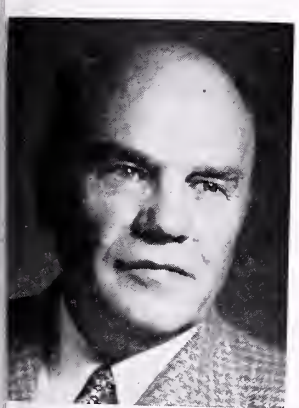
Fat in the diet may not initiate atherosclerosis, but it appears to be the major factor in aggravating it

Coronary Atherosclerosis in Ethnic Groups

A Series of 2,000 Autopsies

NILS P. LARSEN, M.D., Honolulu AND
WALTER BORTZ, M.D., San Francisco

THE POLYNESIAN is not a race, but a mixed people. The anthropologists recognize that this mixing took place within Polynesia. Today, Hawaii is a great mixing pot of many races. It will probably become a developing spot of a new race, as indicated by the fact that in one year 38 per cent of the Caucasian bridegrooms married non-Caucasian brides.



DR. LARSEN

Because of the presence of many different races in Hawaii, the authors believed a careful look at the coronaries at death might throw more light on atherosclerosis. They first studied a series of 1,250 postmortems and showed striking atherosclerotic differences in the coronaries of the different races. The report on their findings was presented at the annual meeting of the Hawaii Medical Association in 1954.[1] In 1957 and 1958 they decided to carefully review a longer series and bring the findings up to date.

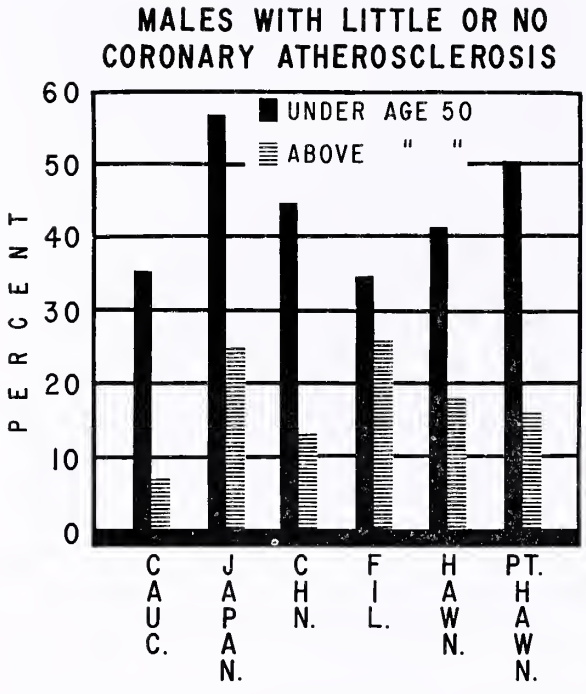
The present study is from a series of about 2,000 consecutive postmortems at The Queen's Hospital (1,213 males, 755 females, from ages 20 to 70). The subjects were divided into groups under and over 50 years of age. Table 1 indicates the number in each race studied, with sex and age, as well as the condition of the coronaries.

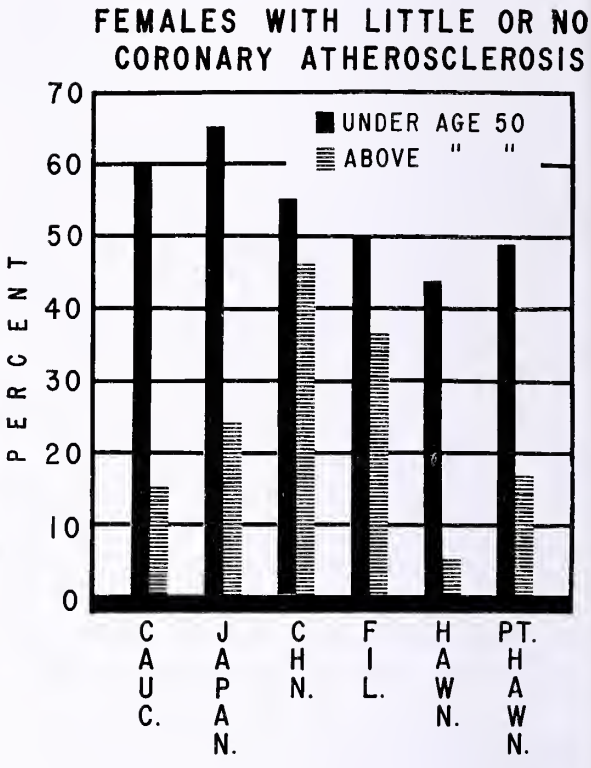
TABLE 1.—*Degree of Coronary Sclerosis in Race, Sex, and Age, with Percentages.*

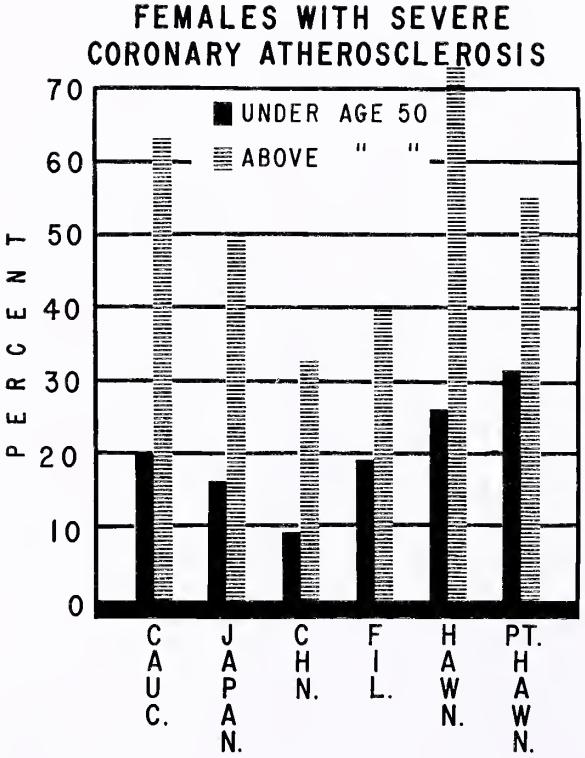
	TOTAL	0 PLUS 1		2		3 PLUS 4	
	NO.	NO.	%	NO.	%	NO.	%
Caucasian M							
under 50	121	43	35	37	30	41	33
over 50	453	37	8	82	18	331	82
Caucasian F							
under 50	75	45	60	15	20	15	20
over 50	303	47	15	65	21	191	62
Japanese M							
under 50	40	23	57	11	27	6	15
over 50	124	32	26	42	34	49	40
Japanese F							
under 50	52	35	67	8	15	9	17
over 50	51	12	23	13	25	25	49
Chinese M							
under 50	18	8	44	6	33	4	22
over 50	50	7	14	9	18	34	68
Chinese F							
under 50	11	6	55	4	36	1	9
over 50	15	7	47	3	20	5	33
Filipino M							
under 50	77	27	35	26	34	24	31
over 50	79	20	26	28	35	31	39
Filipino F							
under 50	16	8	50	5	31	3	19
over 50	25	9	36	6	24	10	40
Hawaiian M							
under 50	27	11	41	8	30	8	30
over 50	60	11	18	13	22	36	60
Hawaiian F							
under 50	30	13	43	9	30	8	27
over 50	62	3	5	13	21	46	74
Pt. Hawaiian M							
under 50	32	16	50	5	16	11	34
over 50	52	8	15	6	11	38	73
Pt. Hawaiian F							
under 50	39	19	49	8	20	12	31
over 50	47	8	17	13	28	26	55

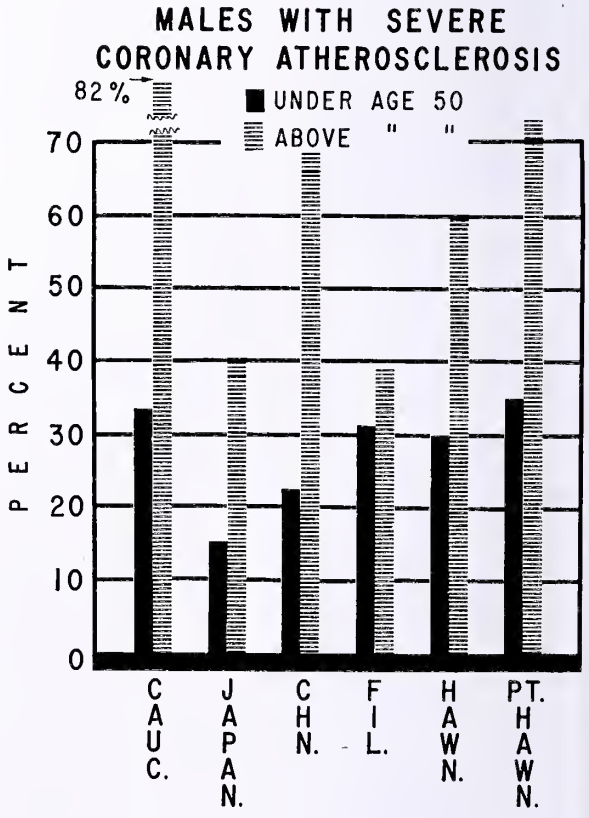
Read before 103d annual meeting of the Hawaii Medical Association, Hilo, April 25, 1959.

[1] Larsen, N. P.: Atherosclerosis—an autopsy study, HAWAII MED. J. 14:129 (Nov.-Dec.) 1954.


MALES WITH LITTLE OR NO CORONARY ATHEROSCLEROSIS
UNDER AGE 50
ABOVE " "
PERCENT
60
50
40
30
20
10
0
CAUC.
JAPAN.
CHN.
FIL.
HAWN.
PT. HAWN.


FEMALES WITH LITTLE OR NO CORONARY ATHEROSCLEROSIS
UNDER AGE 50
ABOVE " "
PERCENT
70
60
50
40
30
20
10
0
CAUC.
JAPAN.
CHN.
FIL.
HAWN.
PT. HAWN.


FEMALES WITH SEVERE CORONARY ATHEROSCLEROSIS
UNDER AGE 50
ABOVE " "
PERCENT
70
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CAUC.
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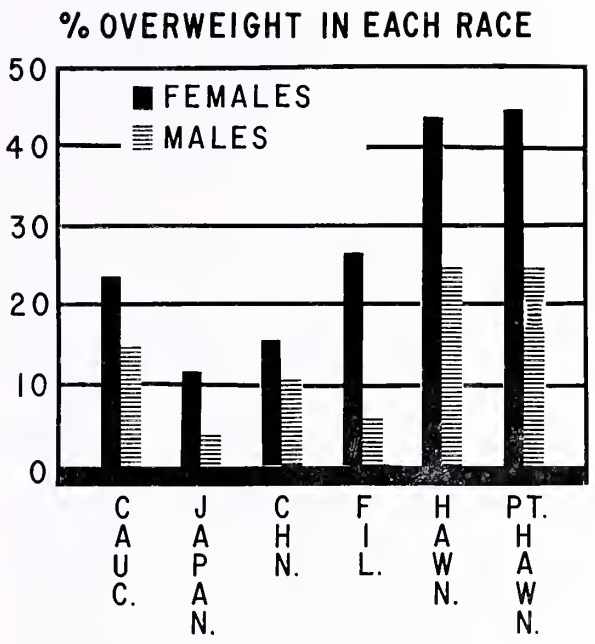

MALES WITH SEVERE CORONARY ATHEROSCLEROSIS
82%
UNDER AGE 50
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PERCENT
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Graphs 1 through 4 are a translation of these figures into bar graphs, using the evaluation 0, 1, 2, 3, 4, to indicate increasing coronary deposits. For convenience, we combined groups 0 and 1, and groups 3 and 4. We omitted classification 2 in the graphs so as to omit borderline cases. The senior author, who read the degree of atherosclerosis, did not know the sex, age, or race of the subject.

The state of nutrition was also noted; classified as thin, thin with wasting disease, normal, and overweight. Graph 5 indicates in percentages the findings of overweight for sex and race. This was an estimation by appearance, no calipers were used. The few with "thin with wasting disease" added nothing of value. It will be noted that in each racial group a significantly higher percentage of women were overweight than men. This was more true in people over 50 than in the younger years. Yet even in those under 50 among the Japanese, Chinese, Filipino, and part-Hawaiian, there were more overweight women than men. The Caucasian and Hawaiian women and men under 50 were evenly balanced, with only three per cent in each female group overweight.

In comparing these groups with the condition of their coronaries, Graphs 1 through 4 indicate that the women have generally cleaner arteries with less severe atherosclerosis than the men. However, women over 50 are well on their way in catching up with the men in severity of damage, and in some cases Japanese and Hawaiians over 50 show more women than men with severe atherosclerosis. This would suggest that overweight alone is not sufficient to account for all increase in coronary atherosclerosis. Also, the Hawaiians and part-Hawaiians are heavy eaters and tend to be fat. They are not now on a standard diet, and eat with whatever group they are with, but they eat well. More Hawaiians, both men and women, were overweight than the subjects of any other race (see graph 5). If overweight alone were the cause, the Hawaiians should have an overwhelming amount of atherosclerosis. It will be noted they come close to the Caucasians. From the racial standpoint they are a Caucasoid and not a Negroid people. From the arterial standpoint they are slightly below the Caucasians in the number with severe atherosclerosis.

Striking differences in weight are noted in certain other groups. (A complete study of the Japanese versus the Caucasian is now in preparation.) In evaluating the percentage of thin patients in two groups, for instance, 51 per cent of the Japanese men were thin, compared to 30 per cent of the Caucasian men. Among the women, 28 per cent of the Japanese women were thin, and 30



per cent of the Caucasian women. Japanese women with severe coronary damage showed 17 per cent under 50 and 49 per cent over 50, whereas the Caucasian women showed 20 per cent under 50 and 62 per cent over 50 with the same severe lesions.

A series of 369 hypertensives and 44 diabetics of all races were evaluated as to the degree of atherosclerosis of the aorta. It was found that 15 per cent of high blood pressure cases were rated with little atherosclerosis and 64 per cent were rated as having severe. In the diabetics, 15 per cent had little and 64 per cent had severe lesions. The average for the total series showed 25 per cent with little and 50 per cent with severe. It is evident hypertension and diabetes can occur with a minimum of damage in the arteries, but there is a definite indication these two conditions tend to be associated with more severe deposits. The recorded heart weights did not seem of significance in relation to atherosclerosis.

Verification in this study is noted for conclusions given in many different reports, i.e. that there is an increase in the amount and severity of atherosclerosis with age and there is a lessened amount of this condition in women, especially in those under 50 in each group studied. It is also evident that atherosclerosis is a universal condition that occurs in all races and to some degree in most individuals from 20 years up. However, in each group there are a fair number in the "under 50" age group who have severe atherosclerosis and a number in those "over 50" who have clean arteries. Heredity is probably a factor. However, if it were the only factor producing these

variations, one would not expect the marked differences shown in a previous paper[2] in the Japanese in Japan, in Hawaii, and in Los Angeles. Emotional stress, we believe, is less in Hawaii than in Japan. Rural people in Hawaii have assured incomes, homes, churches, sports, schools for their children, and paid vacations.

Although women in each group have less severe atherosclerosis than the men in the same group, the Caucasian woman has more severe arterial lesions (even in the under-50 age group) than the Japanese man. Estrogen differences alone cannot account for such findings. It lends support to Burr's report[3] that women have a metabolic superiority in handling fat (if the increased deposit is due to fat). That may be related to estrogenic activity, but not necessarily due to it. When a woman consumes the amount of fat eaten by the Caucasian she apparently loses her metabolic superiority (as she does after the menopause) over men; hence Japanese men, with a much lower estrogenic level, have less arterial deposits than Caucasian women.

These findings add support to the theory that diet may cause an increase in atheromatous deposits in the arteries, even though it may have no role in initiating the condition. It suggests we should stop thinking in terms of diet as the cause of atherosclerosis, but that variations in diet may increase the degree of deposits in the plaques and therefore make occlusion or thrombosis more likely.

In all diseases and from all causes that are associated with a rise in blood cholesterol are found increased arterial deposits. Therefore if a high blood cholesterol is found one is justified in suspecting an increased deposit in the arteries. Since injection of hard fat can (in most subjects) produce a rise in blood cholesterol, it would seem fair to assume that it may well be responsible for an increase in atherosclerosis. The Japanese on a relatively low fat diet have a low blood cholesterol and a low incidence of coronary disease, whereas the U.S.A. on a high fat diet has a high blood cholesterol and a high percentage of its people with illness from coronary atherosclerosis. Japanese in Los Angeles, living on the U.S.A. diet, tend to change in the same way—higher fat, higher cholesterol, and higher incidence of coronary disease.

The other diet factors that experimentally can produce arterial lesions are not present in these two groups of people. The difference in fat intake seems to be the only striking difference relative to experimental atherosclerosis. It does seem it may well have real significance. Added to this is the fact that the Japanese in Hawaii have more severe atherosclerosis and a higher percentage of coronary thrombosis than do the Japanese in Japan.

Table 2.—*Degree in Per Cent of Atherosclerosis of Coronary Artery in the Different Race Groups in Order of Severity (Age 20-70)*

RACE	TOTAL % WITH CLEAN (0 PLUS 1) ARTERIES	TOTAL % WITH SEVERE (3 PLUS 4) LESIONS
Japanese	44	31
Chinese	40	33
Filipino	37	33
Hawaiian	33	48
Pt.-Hawaiian	28	49
Caucasian	30	50

Recently, Dr. T. Imai of Kyushu University was in Honolulu with a series of formalinized coronaries and charts based on autopsy findings. It seemed evident to him, as well as to us, that there was a striking difference in the degree of atherosclerosis among the Japanese in Japan as against the Japanese in Honolulu.

All the races are now eating more and more of the Caucasian foods—and probably there is no child in Hawaii who has not learned the delights of ice cream, milk, eggs, and butter. If the significant factor is diet, in the course of the next 20 years (unless diet habits can be changed) the racial arterial differences shown in this paper should disappear. These are summarized in Table 2.

Summario in Interlingua

Le constatationes microscopic con respecto al grado de atherosclerose coronari in 2.000 necropsias consecutive in Hawai tende a confirmar le conviction del autor que un alte ingestion de grassia animal es un del plus importante factores causative in le production de ille disordine, ben que illo non initia le processo indirectemente.

1137 Eleventh Ave.

[2] Keys, A., Kimura, N., Kusukawa, A., Bronte-Stewart, B., Larsen, N., and Keys, M.: Lessons from serum cholesterol studies in Japan, Hawaii, and Los Angeles, Ann. Int. Med. 48:83 (Jan.) 1958.

[3] Burr, G. O., and Burr, M. M.: On the nature and the role of the fatty acids essential in nutrition, J. Biol. Chem. 86:857 (Apr.) 1930.

Electrocardiography on newborns is done easily and safely with the help of this ingenious electrical device

An Apparatus for Electrocardiography on Infants

JOHN R. STEPHENSON, M.D.,* Honolulu

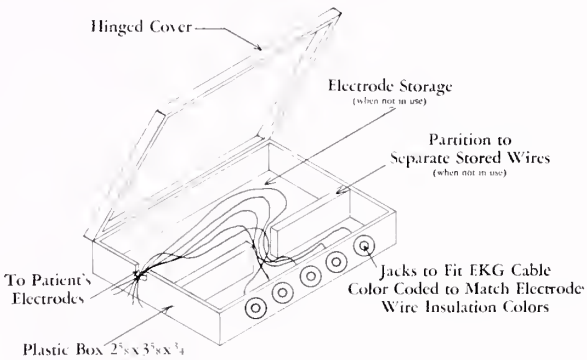
TAKING an EKG on an infant is difficult: usually the electrodes are not small enough, and the patient cannot cooperate. To take a record on a premature infant, or any infant in an incubator, is even more difficult. With the standard equipment usually available, this involves a serious break in the "clean technique" of the nursery when the electrodes and the patient cable of the machine are brought inside the bassinet or incubator. These instruments most likely have recently been on another patient's bed, and although they are constructed so that they can be decontaminated by soaking, they seldom if ever are.



DR. STEPHENSON

These facts generally weigh heavily against the decision to obtain a record in the newborn nursery. To overcome this, we have built a small adaptor for the EKG. It consists of long insulated conducting #20 wires with small concave metallic discs, about 1 cm. in diameter, soldered to their ends (a conventional electroencephalograph electrode and wire will suffice). The other end of the wires is soldered to a female plug into which the standard EKG jacks will fit, and the whole assembly is mounted in a small plastic box. Different colored insulation is used on each wire, and the plug to which it is connected is painted the same color.

When in use, the small box is placed on top of the incubator and the wires leading from it passed through a porthole with the terminal discs fixed to the patient's extremities by means of EKG paste and cellulose tape. The chest leads are similarly fixed. When not in use the wires fold up inside the small box. The EKG paste used has been modified by adding sufficient Bentonite powder to make it of heavier consistency so it will not spread out under the tape and cause the tape to loosen. After the leads are attached to the patient, the jack



for the standard EKG patient cable is plugged into the appropriate plug on the plastic box as indicated by its color and the color of the wire attached to each limb. The record is then taken by the usual technical procedures.

There are several advantages to this apparatus. The whole apparatus can be soaked in antiseptic solution, dried and kept in the nursery ready for use. The potentially contaminated electrodes and wires of the standard machine need not enter the incubator. The small size of the electrodes makes them easy to apply to the chest, and facilitates more accurate placing. The length of the wires and their very light weight tend to prevent them from being disconnected from the patient when he kicks, as he probably will.

In the process of our studies with this apparatus, it was noted that the heater on the one incubator did not cause too much interference; however, if more than one or two incubators were connected to the same source of power as the EKG machine, too much 60 cycle interference was experienced. This was quickly overcome by turning off the heaters of the other incubators while the record was being taken.

We have tested this apparatus under various circumstances at the Kapiolani Maternity Hospital and the Kauikeolani Children's Hospital, and are impressed with the good results obtained on infants in an incubator. Although we are convinced of its usefulness, we make no claim for originality.

Summario in Interlingua

Le grande dimensiones del electrodos e le inconveniente de sterilisar le filos e le electrodos es factores que milita contra le obtention de electrocardiogrammas ab neonatos, specialmente in le caso de prematuros qui es mantenite in incubatores.

Le autor describe un simple garnitura de connexiones electric, incluse micre electrodos, que es facile a sterilisar e que assi rende possibile le uso del electrocardiographia in le caso de infantes in incubatores sin violar le technica del continue sterilitate.

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Portocaval shunt, in selected cases of bleeding esophageal varices, is highly effective in stopping further hemorrhage

Hemorrhage from Esophageal Varices: Surgical Management

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PORTAL hypertension is caused by an obstruction to the outflow of blood from the portal bed due to one of several causes. In some way, as yet not completely explained, this portal hypertension is related to the occurrence of hemorrhage from esophageal or gastric varices, or both, which develop as a result of the increased venous pressure.

Credit for recognition of the role of portal hypertension in the development of esophageal varices must be given to Allen O. Whipple,[1] Louis M. Rousselot[2] and their associates at the Spleen Clinic of the Presbyterian Hospital in New York City. In their studies of children afflicted with the mysterious entity known as Banti's syndrome, they discovered and measured the increased pressure in the portal bed. Further studies brought out the role of lesions of the liver, particularly Laennec's cirrhosis, in this condition.

In 1945, Blakemore[3] reported a successful shunt between the portal and caval circulation (Eck's fistula), with resultant reduction of the portal venous pressure and protection of the patient against further hemorrhage from varices. Since these initial studies, numerous workers have performed exhaustive investigations of the pathologic physiology involved in this condition and numerous surgeons have made reports upon the performance of shunt procedures for the relief of portal hypertension. There is no unanimous opinion regarding the ability of such shunts to prevent hemorrhage from varices, but Longmire,[4] Linton,[5] Blakemore, and others have had favorable experience in their use. Others, especially Bennett,[6] Taylor,[7] and Ripstein,[8] have cast some doubt upon their need or efficacy, pointing to the uncertain natural history of the untreated disease. Cohn[9] and others point to the high mortality from the first hemorrhage and a lower mortality from subsequent episodes as an argument against the need for surgical treatment of portal hypertension.

Pathologic Physiology

The causes of portal hypertension are most conveniently divided into intrahepatic and extrahepatic lesions. Under the former the most common lesion is portal or Laennec's cirrhosis. In this con-

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[1] Whipple, A. O.: Problem of portal hypertension in relation to hepatosplenopathism. Ann. Surg. 122:449, 1945.

[2] Rousselot, L. M.: The role of congestion (portal hypertension) in so-called Banti's syndrome. J.A.M.A. 107:1788 (Nov. 28) 1936.

[3] Blakemore, A. H., and Loro, J. W., Jr.: The technic of using vitallium tubes in establishing portocaval shunts for portal hypertension, Ann. Surg. 122:476, 1945.

[4] Longmire, W. P., Jr., Mulder, D. G. Mahoney, P. S., and Mellinkoff, S. W.: Side to side portocaval anastomosis for portal hypertension. Ann. Surg. 147:881, 1958.

[5] Linton, R., and Ellis, D. S.: Emergency and definitive treatment of bleeding esophageal varices. J.A.M.A. 160:1017 (Mar. 24) 1956.

[6] Bennett, H. D., Lorentzen, C., and Baker, L. A.: Transient esophageal varices in hepatic cirrhosis. Arch. Int. Med. 92:507, 1953.

[7] Taylor, F. W.: Portal tension and the dependence on external pressure. Ann. Surg. 140:652, 1954.

[8] Ripstein, C. B.: Experiences with portocaval anastomosis—the treatment of portal hypertension. Surg. 34:570, 1953.

[9] Cohn, R., and Blaisdell, F. W.: The natural history of the patient with cirrhosis of the liver with esophageal varices following the first massive hemorrhage. Surg. Gyn. Obst. 106:699, 1958.

dition, as a result of the portal fibrosis, there is obstruction to the venous radicles which distribute the portal blood through the liver parenchyma. As this fibrosis progresses and involves more numerous venous radicles and occludes them more severely, the portal pressure increases. This increase in portal pressure is contributed to, at least in some degree, by the presence of shunts between the hepatic arterial blood supply and the venous channels. As a result of the increased portal venous pressure, collateral channels are formed or enlarged, or both, including the troublesome varices. The occurrence of ascites, on the other hand, is not due to this increase in portal pressure; it is rather thought to be the result of liver insufficiency with associated malnutrition and hypoproteinemia.

Other causes of intrahepatic portal obstruction include biliary cirrhosis, and a case illustrating this lesion will be included in this report. Schistosomiasis of the liver in some parts of the world is a common cause of portal hypertension; Stock of Hong Kong has reported this feature. Occasionally, extensive carcinoma of the liver, particularly the primary type, may result in portal hypertension.

The extrahepatic type of obstruction to portal blood flow is much more commonly seen in children, in whom this condition used to be called Banti's syndrome. It is now known that this syndrome, previously thought to be a primary enlargement of the spleen with subsequent involvement of the liver by some mysterious process, is really a result of obstruction of the extrahepatic portion of the portal or splenic vein, or both, with the resultant development of portal hypertension. This obstruction of the portal vein may be the result of a recognized, or possibly unrecognized, episode of sepsis in early infancy, with thrombosis of the portal vein and subsequent recanalization. This recanalization is incomplete, and progressive increase in the portal venous blood pressure occurs.

Another entity of unknown cause is the so-called cavernomatous transformation of the portal vein, which is usually also seen in children with Banti's syndrome. This lesion is of unknown etiology, but may be a variation of the recanalization that occurs after a portal vein thrombosis and the simultaneous attempt at formation of venous collaterals. Sometimes this occlusion of the extrahepatic portal system is confined to one segment, particularly the splenic vein. This may be the result of trauma. Hypersplenism is common in patients with extrahepatic portal obstruction but also can accompany cirrhosis.

The role of the increased venous pressure in the development of esophageal varices and other venous collaterals is apparent; yet it is not the only factor at work in the production of hemorrhage. There is no direct relationship between the level of portal hypertension and the incidence or size of the esophageal varices. The role of arteriovenous shunts within the liver between the hepatic arterial blood supply and the portal venous return, and the complex physiology resulting from them, have been emphasized to explain this discrepancy. In the extrahepatic type of portal hypertension, however, the venous pressure seems to be the only factor at work in the formation of the varices.



DR. FREEMAN

In association with the increased portal venous pressure, various venous collaterals are formed in an attempt to carry off the portal blood flow by routes other than the portal vein. These collaterals can be seen as dilated veins in the skin of the abdominal wall, internal hemorrhoids, and esophageal varices.

Hemorrhage from esophageal varices does not occur in all patients with cirrhosis of the liver, and other factors have been postulated in its development. It does not depend on the level of the portal venous pressure. Peptic erosions in the lower esophagus or proximal stomach have been postulated as the initiating cause in hemorrhage. These erosions are especially likely to occur because the varices may be so large that incompetence of the cardia occurs, permitting the reflux of acid gastric contents.

Massive Hemorrhage, an Emergency

Hemorrhage from esophageal varices is likely to be severe and even catastrophic. Once the blood vessel has ruptured, the increased venous pressure in the portal circuit, and the inability of the veins to retract, perpetuate the hemorrhage. Because of the large volume of blood flowing through this circuit, the loss can be tremendous in a very short period of time. Occasionally the hemorrhage is much less severe, but this is the exception rather than the rule.

The cirrhotic patient who sustains such a massive hemorrhage is poorly equipped to withstand it. The patient with extrahepatic portal obstruction has much more in his favor. In both, as a result of the loss of blood, shock occurs; but in a cirrhotic patient, in addition, there is a great tendency for the development of coma and liver fail-

ure. The mechanism of this coma is not completely understood, but the elevation of blood ammonia has been noted and this is thought to have a cerebral toxic effect (Eiseman[10]). The elevation in blood ammonia results from the breakdown of blood in the gastrointestinal tract by bacterial action, the absorption of ammonia into the blood stream from the gut, and the failure of the liver to metabolize this toxic substance. This explanation has seemed too pat for some students of this disease and there well may be other important factors at work in the development of coma under these circumstances. Yet it is well known that coma does not occur in the individual who has an equally massive blood loss from varices due to extrahepatic portal obstruction.

Suffice it to say that this hemorrhage must be controlled or the patient will be lost. Emergency measures to control it include blood transfusions and other supportive steps. Attempts to control the hemorrhage directly take two forms.

Balloon tamponade by means of the Sengstachen[11] tube is generally accepted as the first measure to be employed. This tube is inserted transnasally; the gastric balloon inflated; the balloon is then drawn up against the cardia of the stomach and held in this position either by traction or tape to the nose, after which the esophageal balloon is inflated to a known pressure, using either a mercury or water manometer. This pressure in the esophageal balloon, assisted by that in the gastric balloon, is designed to control the loss of blood from the esophageal varices. This may sound simple, but it is fraught with many pitfalls and must be used with caution.

If this fails, Linton advocates the emergency operative control of bleeding by transesophageal ligation of the varices. This necessitates a thoracotomy through which the esophagus is opened and the varices obliterated by continuous absorbable sutures. He emphasizes, however, that this must not be considered a permanent method of control: a portocaval shunt should be attempted within six to eight weeks.

Definitive Surgery

Once the patient with hemorrhage from esophageal varices has been stabilized and the hemorrhage controlled, by whatever means necessary, definitive surgical treatment must then be considered. Although there are still those who doubt the efficacy of this procedure, most surgeons feel that a patent shunt between the portal and caval systems will protect the patient from further hemorrhage in from 90 to 95 per cent of cases (Longmire). If subsequent hemorrhage should occur, it will be of minor degree and not a threat to survival (Longmire).

The surgeon has at his command several possible procedures. The most direct of these is the creation of a shunt between the portal and caval venous systems, either portocaval or splenorenal. A fundamental principle is that it must be large enough to divert a significant quantity of blood and done in such a manner and in such a location that it has the best chance of remaining patent. A shunt between the portal vein and inferior vena cava most nearly satisfies these requirements and is the procedure of choice in the presence of intrahepatic portal obstruction.

However, it is not always feasible to perform this procedure (Case 4). In the presence of extrahepatic portal obstruction, it is usually impossible. In these cases, a shunt between the splenic vein and renal vein is thought to be the procedure of choice, but this can be very difficult and the shunt is prone to thrombose (Case 5). DeBakey and his group, on the other hand, prefer surgical resection of the lower one-third to one-half of the esophagus and the fundus of the stomach, and intrathoracic esophagogastrotomy. Though they maintain that this removes the source of bleeding, it seems unwise to us to ignore the fundamental pathologic physiology of this condition. However, in certain instances, such a procedure may be the only recourse left (Case 5).

Selection and Preparation of the Patient

Having decided that surgical treatment must be considered, the surgeon must evaluate other factors before it can be performed. This is particularly true of the patient with cirrhosis. Before this extensive surgical procedure is attempted, the patient's general condition must be brought to a point of maximum improvement. Obviously he cannot be brought to normal, for cirrhosis is not a reversible disease. However, supportive measures should include a well-balanced high-protein, high-vitamin diet and supplements such as choline and methionine. These may be particularly important in the patient of poor economic status or the severe alcoholic who has been in a state of chronic semi-starvation. Alcohol, of course, must be removed from the patient's diet.

Liver function studies, particularly serum proteins, prothrombin time, and bromsulphalein excretion, help in evaluating the patient's status and response to this supportive program. This treatment must be continued for a few weeks or perhaps even several months, until such time as the maximum improvement has occurred. Ascites is

[10] Eiseman, B., Bakewell, W., and Clark, G.: Studies in ammonia metabolism. Am. J. Med. 20:890, 1956.

[11] Sengstachen, R. W., and Blakemore, A. H.: Balloon tamponade for the control of hemorrhage from esophageal varices. Ann. Surg. 131:781, 1950.

TABLE 1.—*Tabulation of ten cases subjected to shunt procedures for portal vein obstruction.*

CASE AND DATE OF SURGERY	AGE	SEX	CAUSE OF PORTAL HYPERTENSION	INDICATION FOR SURGERY	PORTAL PRESSURE	PROCEDURE	FOLLOW-UP	REMARKS
Case 1 6-21-56	51	F	Portal cirrhosis	2 moderate hemorrhages in 6 mo.	380-400	End-to-side portocaval shunt	No hemorrhage 2 yr.	Varices disappeared post-shunt
Case 2 9-20-55	49	M	Portal cirrhosis (preop. "duodenal ulcer").	3 moderately severe hemorrhages	?	Side-to-side portocaval shunt	No hemorrhage 3⅓ yr.	Liver function unchanged
Case 3 11-5-52	6½	M	? congenital valve portal vein	2 large hemorrhages before and 1 after splenectomy. Hypersplenism	500	End-to-side portocaval shunt	No further hemorrhages 6 yr. Disappearance of varices	Splenectomy failed to control hemorrhages
Case 4 9-20-54	45	F	Biliary cirrhosis due to common duct stricture, hypersplenism	Several moderate hemorrhages Hypersplenism	?	Omentorenal shunt, end-to-side	? 1 minor hemorrhage	Death from liver failure (?) 3 yr. postop. Splenoportography helpful
Case 5 1-12-56 7-23-57	4	F	Portal vein thrombosis	2 exsanguinating hemorrhages	?	1. Splenorenal shunt 1-12-56 2. Transesophageal ligation of varices 7-23-57	Shunt thrombosed Hemorrhage. No further hemorrhages 1⅓ yr.	Splenoportography helpful. Gastroesophageal resection may be necessary
Case 6 1-13-50	35	M	Portal cirrhosis	1 massive hemorrhage	400	End-to-side portocaval shunt	Postop. death	Poor selection for surgery with liver and renal insufficiency Technically poor anastomosis
Case 7 3-7-57	58	F	Portal cirrhosis	1 massive hemorrhage	?	End-to-side portocaval shunt	Severe liver insufficiency with jaundice and ascites Postop. empyema Death	Severe hemorrhage in patient with poor liver reserve. Surgery a desperation measure
Case 8 9-19-52	23	M	Portal cirrhosis	Hypersplenism Large varices	380	Side-to-side portocaval shunt	Doing well 6 yr. postop. No hemorrhages	None
Case 9 8-24-56	46	M	Portal cirrhosis	1 large hemorrhage	350	End-to-side portocaval shunt cholecystectomy	No further hemorrhages 2½ yr. postop.	Has recurrent unexplained febrile episodes with painless hematuria
Case 10 3-12-57	65	F	Portal cirrhosis	1 exsanguinating hemorrhage	500 then 240	End-to-side portocaval shunt	No further hemorrhages 2 yrs. postop.	Preop. liver function studies normal

in most instances due to poor liver function and, if this can be improved, usually will recede. The patient without liver disease is, of course, a much less difficult problem from the standpoint of preparation for surgery and usually all that is necessary is restoration of blood volume and a short period of convalescence from the hemorrhage before surgery.

Technique

The technical aspects of the procedure differ in only a few respects from other types of vascular surgery. One of these is the surgeon's choice between a side-to-side and end-to-side shunt between the portal vein and vena cava. The end-to-side shunt—in which the portal vein is ligated at the hilum of the liver and the distal segment is used for anastomosis to the side of the vena cava—is the easiest to perform, and most surgeons prefer it for this reason. It is also preferred on the ground that a side-to-side anastomosis may permit, in effect, a dangerous arteriovenous shunt. Longmire, however, has found no evidence of such ill effect. He favors this side-to-side anastomosis.

The splenorenal anastomosis was originally performed after removal of both the spleen and the kidney, but more recently has been done without nephrectomy. Technically, this procedure is difficult because the splenic vein is extremely fragile and the shunt is prone to undergo thrombosis. This event is favored because the shunt depends upon a retrograde flow of blood from the splenic vein through the renal vein into the vena cava. In addition, the splenic vein must be dissected out for some distance. Great care is necessary to prevent angulation where it is anastomosed to the renal vein. These difficulties and the possibility of thrombosis are avoided by a portocaval shunt and make this the preferred procedure whenever it is possible to do so.

Illustrative Cases

CASE 1.—A 51-year-old Japanese housewife, first seen on June 12, 1956, had been well except for profuse hematemesis occurring one and five months before. There was no history of jaundice and no exposure to toxic substances except the use of insecticides in her garden.

She was a moderately obese, short, thick-set woman, in no distress. There were no significant positive physical findings. Liver and spleen could not be felt; there were no stigmata of liver disease.

Red blood count was 4,570,000; hemoglobin 12.3 grams; white blood count 8,250 with 39 per cent polys, 61 per cent small lymphs; total serum protein 7.5; albumin 4.1; globulin 3.4; total bilirubin 1.4 mg per cent, direct .7 mg per cent and indirect .7 mg per cent; thymol turbidity 3 units; zinc turbidity 16.5 units; prothrombin time 100 per cent of normal; bromsulphalein retention was 14 per cent in one-half hour; serologic test for syphilis: Eagle negative and Kolmer 4+.

Gastrointestinal x-ray examination showed large distinct varices in the lower one-half of the esophagus and no ulcerating lesion was seen in the stomach or duodenum.

On June 21, 1956, exploratory laparotomy was performed at The Queen's Hospital. The liver showed typical hobnail cirrhosis, grossly and microscopically. The spleen was moderately enlarged. There was little collateral circulation between the portal and caval systems. Portal pressure in an omental vein was 380 to 400 mm of water. The incision was extended into the lower right chest, the diaphragm incised, permitting dislocation of the liver into the pleural cavity, and an end-to-side portocaval shunt performed (Figure 1). The patient had an uneventful postoperative recovery and was discharged on the tenth day after operation.

Follow-up x-rays of the patient no longer show the esophageal varices. Thymol turbidity is now 9.4 units and the zinc turbidity 19.2. The cephalin-cholesterol flocculation test (not done preoperatively) is 4+. The serum proteins are normal. There have been no further hemorrhages. However, the patient has had several attacks of right upper quadrant pain suggestive of gallbladder disease. Visualization of the gallbladder on two occasions, however, has showed no evidence of calculi and surgery has not been advised.

Comment

This patient was an ideal candidate for the performance of a portocaval shunt, being in good general condition at the time surgery was considered. Her previous hemorrhages had not been severe enough to be a threat to her life or to cause coma. In spite of an unfavorable physique, a thoracoabdominal incision permitted the performance of a portocaval shunt without unusual technical difficulties. The patient made an excellent recovery from her surgery and no further hemorrhages have occurred. The laboratory evidence indicates some progression in her liver disease, but this has not been evident by clinical symptomatology.

Case Reports Continued

CASE 2.—A 49-year-old Japanese man was first seen at the Straub Clinic with gastrointestinal complaints in October, 1946. There were no positive physical findings. Gastrointestinal x-ray examination was negative and the patient was given symptomatic treatment. He was followed from that time at irregular intervals with intermittent digestive complaints. Repeat gastrointestinal series in 1950 and 1953 showed minimal evidence of duodenal ulcer and appropriate therapy was instituted.

In May, 1955, while on a trip, he had his first episode of bleeding, and in July, 1955, he vomited blood and had tarry stools. This responded to conservative treatment and subsequent x-ray examinations showed evidence of chronic duodenal ulcer, but no crater was identified. At no time were esophageal varices noted. Surgery was recommended as an elective procedure, but not until after his third hemorrhage in September, 1955, did the patient acquiesce. Routine preoperative laboratory work-up, including serum proteins, gave no indication of liver disease. At no time was hepatomegaly noted, but the spleen was felt once.

At operation, on September 20, 1955, at The Queen's Hospital a considerable amount of ascites was noted. The liver had the characteristic hobnail appearance of Laennec's cirrhosis, the spleen was enlarged and the veins of the greater and lesser omentum were distended.



FIG. 1.—Completed end-to-side portocaval shunt (Case 1).

There was no evidence of any ulcerating lesion in the stomach or duodenum. A biopsy of the liver confirmed the presence of portal cirrhosis with no evidence of hepatoma. It was decided to proceed with a portocaval shunt.

To accomplish this, the vertical abdominal incision was extended diagonally across the right lower chest in the fifth interspace, the diaphragm was incised and the liver dislocated into the chest, permitting adequate dissection and exposure of the inferior vena cava and the portal vein. A side-to-side anastomosis was done, and upon release of the clamps a thrill was noted on the lateral aspect of the vena cava opposite the orifice of the shunt, indicating the presence of a jet stream of blood from the opening in the portal vein. The patient made an uneventful recovery from surgery.

Postoperative studies showed definite evidence of disease of the liver parenchyma. The cephalin-cholesterol flocculation test was 4+ and the zinc turbidity 14.2 units. Questions regarding possible causes brought out the information that the patient had been experimenting extensively with plant and insect poisons.

Since the operative procedure, the patient has had no further episodes of hemorrhage. Careful follow-up has revealed continued evidence of liver insufficiency with a persistently elevated cephalin-cholesterol flocculation test.

This patient is similar to Case 1 in that his hemorrhages had not been exsanguinating and an elective portocaval shunt was done. In both of these patients the only possible cause that could be elicited was the use of plant and insect poisons, but their exact role cannot be determined.

CASE 3.—A five-year-old boy, under the care of the Straub Clinic since birth, was first seen with gastrointestinal hemorrhage. Because of projectile vomiting which began at the age of three weeks, exploratory operation was done for possible pyloric stenosis. No such lesion was found. Following this operation, he developed normally with the usual childhood illnesses until his admission to The Queen's Hospital at age five, on May 13, 1951, with a history of vomiting blood. This recurred

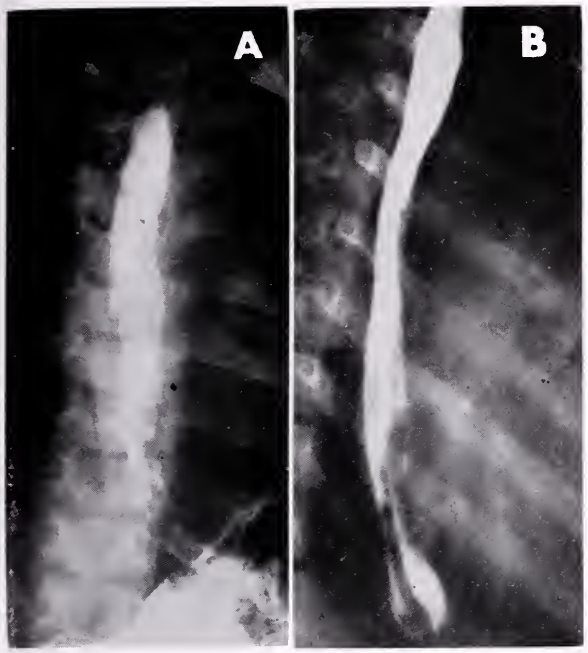


FIG. 2, A AND B.—Esophagograms showing preoperative esophageal varices and postoperative resolution after successful portocaval shunt (Case 3).

several times during the next two days and required transfusions of whole blood during this time. The bleeding stopped without more active treatment and subsequent study showed possible esophageal varices. A duodenal ulcer could not be ruled out. It was noted that the spleen was enlarged two fingerbreadths below the costal margin. Liver function studies were within normal limits and there was no retention of bromsulphalein.

On January 26, 1952, the patient vomited 200 to 300 cc of blood at home. He was immediately hospitalized and hemorrhage continued intermittently for forty-eight hours during which time he received 1,000 cc of blood by transfusion. The blood count at the lowest point was 1,900,000 red cells with 5 grams of hemoglobin. The spleen was still enlarged. After the hemorrhage ceased, the patient was discharged from the hospital and prepared for exploratory laparotomy. He received hematinics which brought his red blood count back to 4,000,000 with 13.6 grams of hemoglobin. Liver function studies continued to show no abnormality.

On April 2, 1952, exploratory laparotomy was performed and the splenomegaly confirmed. There were numerous dilated vessels around the splenic pedicle and around the cardiac end of the stomach. There was no enlargement of vessels in the greater omentum, in the other viscera or in the hepatoduodenal ligament. There were numerous adhesions in the right upper quadrant from the previous laparotomy. These were exceedingly vascular, but no enlarged veins were found. There was no evidence of ulcer of the stomach or duodenum. It was felt that there was no evidence of generalized portal hypertension and in the presence of a normal-looking liver it was thought that he had an extrahepatic type of obstruction, probably a result of thrombosis of the splenic vein. Consequently, the spleen was removed and no shunt was attempted.

The boy made a good recovery from this operation, but on August 17, 1952, experienced a third episode of gastrointestinal hemorrhage. This hemorrhage was controlled with the aid of the Patten tube for esophageal tamponade and this was left in place for twelve hours. Bleeding did not recur after the tube was removed. Recovery from this hemorrhage was complicated by an unexplained febrile episode accompanied by abdominal distention and ascites. This was treated with antibiotics, and subsided.

For the next two months, the child ran intermittent fever of unexplained origin. He was maintained on tetracycline during most of this period. He ate poorly and seemed generally in ill health. Further surgery was decided upon and operation performed on November 5, 1952. At operation, the liver was still normal in appearance, but there were many adhesions in the upper abdomen from the two previous operations. Pressure in one of the veins of the jejunal mesentery was almost 500 mm of water. During attempts to dissect out the portal vein, severe hemorrhage was encountered and it was necessary to ligate the portal vein close to the hilum of the liver. The common duct was densely adherent to the portal vein and could not be dissected free and consequently a side-to-side anastomosis between the portal vein and the inferior vena cava was performed. The exact point of obstruction of the portal vein could not be identified. The boy made an excellent recovery from operation and since that time has had no further hemorrhage. A gastrointestinal series shows normal esophagus with no evidence of varices (Figure 2B). The patient has developed and grown in a perfectly normal way and is now a very healthy-looking lad of 14 years.

This patient has been referred to in a previous communication (Burgess,[12] *et. al.*), but a more detailed presentation of his case seemed warranted because of the interesting problems that he presented. It was, of course, a mistake to have performed a splenectomy at the second operation on this boy. Fortunately, for him, however, at the third operation, it was possible to perform a portocaval anastomosis.

The exact cause of this patient's portal obstruction is not apparent. It may be that there is some type of congenital valve present in the portal vein, for we were unable to demonstrate any intrahepatic obstruction due to liver disease or extrahepatic obstruction due to portal vein thrombosis. In any event, he has been protected from further hemorrhage for six and one-half years by a successful portocaval anastomosis.

CASE 4.—A 37-year-old Portuguese woman was first seen in November, 1946, with a history of previous gallbladder surgery followed by a biliary fistula and jaundice. She was also noted to have a splenomegaly. Surgery was performed by Dr. J. E. Strode on November 19, 1946, at which time extensive adhesions in the right upper quadrant were found and no common duct could be identified. After an extensive and tedious dissection, hepatic ducts were located and a Roux Y hepatojejunostomy was performed. The jaundice slowly cleared following this procedure and she returned to her home.

She was seen again in 1948 with an acute nephritis, but no jaundice. At this time the enlarged spleen was again noted and there was evidence of hypersplenism. The white blood count was 2,700 and there was mild anemia.

The patient was seen again in March, 1952, with a history that she had been jaundiced off and on for the previous year. During this time, she had had recurrent attacks of fever and jaundice. She had an enlarged liver and a diagnosis of biliary cirrhosis secondary to chronic long-standing biliary obstruction and infection was made. A secondary laparotomy was performed by Dr. Strode

[12] Burgess, C. M.: Experiences with cardiovascular surgery in Hawaii. Proc. Staff Meet. Straub Clin. 19:45 (Mar.) 1953.

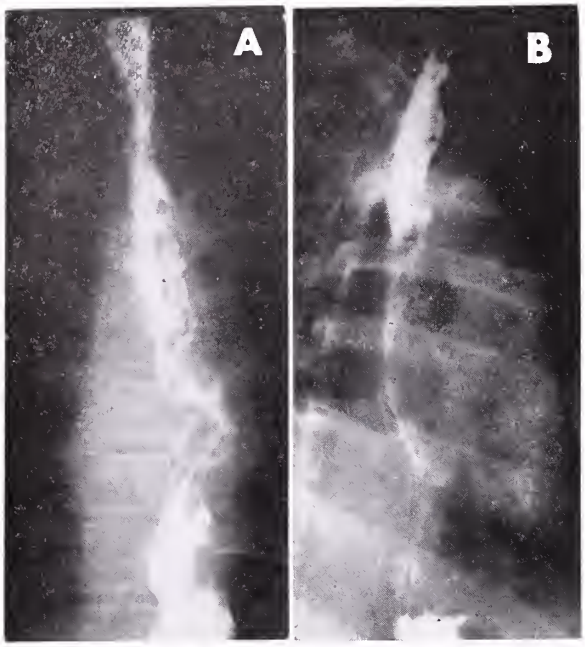


FIG. 3, A AND B.—Esophagograms showing extensive preoperative esophageal varices and postoperative resolution after successful omentorenal shunt (Case 4).

on March 8, 1952. A stenosis of the previous hepatojejunostomy was found, dilated and intubated. Evidence of portal hypertension, including the splenomegaly, was noted. Splenectomy was considered, but thought inadvisable because of the patient's poor general condition. The patient made a good recovery from this procedure and again returned to her home.

She returned in 1954 with a history of severe gastrointestinal hemorrhage requiring multiple transfusions. Studies at this time showed evidences of hypersplenism and portal hypertension with demonstrable esophageal varices (Figure 3A). The T-tube was plugged with debris, but x-ray studies showed the anastomosis to be patent and the T-tube was removed.

The patient was prepared for splenectomy and possibly splenorenal shunt to relieve the threat of hemorrhage. Before operation on March 22, 1954, a percutaneous splenoportogram was done (Figure 4). This showed complete obstruction of the portal vein at the hilum of the liver, probably on the basis of the extensive surgery and severe infection in this area. Accordingly, splenectomy was carried out, but attempts to dissect out a splenic vein for a shunt were unsuccessful due to the extreme friability of the vessel wall. However, an omental vein, at least 1½ cm in diameter, was anastomosed surgically with the left renal vein. Following recovery from this procedure, the patient apparently enjoyed good health for over three years.

On July 19, 1957, she was admitted to the hospital with abdominal pain and coma and in four days died. The cause of death was believed to be liver failure. After her splenectomy and omentorenal shunt, the patient had had only one minor gastrointestinal hemorrhage, which did not require transfusion.

This patient manifested the unusual situation that results from a chronic long-standing common duct stricture with subsequent biliary cirrhosis. This plus the extensive infection and operative trauma apparently resulted in the development of portal hypertension, esophageal varices, and hypersplenism. After an extensive hemorrhage, a splenectomy was performed and a venous shunt performed between an omental vein and the left renal vein. This shunt apparently protected the patient from further hemorrhage during the remaining three years of her life.

CASE 5.—A four-year-old girl was admitted to the Children's Hospital on December 12, 1955, in an almost exsanguinated condition due to a severe gastrointestinal hemorrhage. She had received 15 units of blood during the previous 40 hours, enough to replace her blood volume four times over.

When seen, she was actively bleeding, with fresh blood being expelled from the rectum. In spite of all supportive measures, the hemorrhage continued, and after 12 hours it was decided to do an exploratory laparotomy.

At operation, no bleeding site could be identified. There was no ulcerating lesion of the stomach or duodenum and thorough inspection of the entire gastrointestinal tract showed no cause for the hemorrhage. There were numerous adhesions in the peritoneal cavity and there was an enlarged spleen. The portal pressure in one of the veins in the lesser omentum was over 400 mm of water. The liver was normal in appearance. The abdomen was closed without further procedure being performed and bleeding gradually ceased.

After a period of supportive measures and preparation, a second laparotomy was performed on January 12, 1956, following splenoportography. These x-rays showed complete obstruction of the extrahepatic portion of the portal vein. Accordingly, splenectomy was performed and a shunt made between the distal end of the splenic vein and the side of the left renal vein. The patient made a good recovery from this operation, but three months postoperatively esophageal varices were still present. It was our opinion that the splenorenal shunt had undergone thrombosis.

The varices persisted and in July, 1957, a second hemorrhage occurred. This was not as massive as the first, but required several units of blood. After the child's condition became stabilized and bleeding stopped, exploratory laparotomy was performed on July 12, 1957, and an attempt made to dissect out a portal vein. An extensive dissection of the right upper quadrant was



FIG. 4.—Splenoportogram demonstrating obstruction of the portal vein in the vicinity of the hilum of the liver (Case 4).

performed without demonstrating any usable venous structure in this area. There was marked fibrosis of all the tissue planes, indicating that there had been a severe infection in this area previously. A portocaval shunt could not be performed. Because of the extreme vascularity, several units of blood were needed to support the patient during this dissection and further procedure was not done at this time.

Two weeks later a left thoracotomy was performed and transesophageal ligation of the varices performed. These were found to extend from the level of the hilum of the lung through the esophageal hiatus into the fundus of the stomach. The veins were transfixed and ligated with a continuous running suture of catgut which seemed to give very excellent control of them. The patient made a good recovery from this operative procedure and at the time of writing, almost two years postoperatively, further hemorrhage has not occurred.

This child well illustrates the problem of portal hypertension due to extrahepatic obstruction. She undoubtedly had an episode of sepsis in infancy which resulted in thrombosis of her portal vein with the subsequent development of an enlarged spleen and esophageal varices. The initial exsanguinating hemorrhage from these very nearly caused her death.

Splenorenal shunt was successfully accomplished, but subsequently apparently underwent thrombosis with the result that the varices reformed and hemorrhage recurred. The varices have since been obliterated by a transesophageal ligation and to date hemorrhage has not recurred.

This experience is similar to that reported by Hallenbeck,[13] who now feels that hemorrhage in children should be controlled by esophageal ligation of the varices and that attempts at definitive shunt procedures should be postponed until they are of such an age and size that the shunt will be less likely to undergo thrombosis.

Results

All ten patients treated for portal hypertension by surgical procedures at the Straub Clinic are listed in the accompanying table. It will be noted that there are two postoperative deaths listed. Case 6 succumbed to uremia and liver failure and the results of an imperfectly performed shunt. He was not a good candidate for surgery in the first place because of severe liver and renal insufficiency and his operation was done at a time when technical experience was limited and the newer vascular instruments were not available. The second death, Case 7, was due in large part to her severe liver disease and the development of postoperative liver failure with severe jaundice. Her demise was hastened by the development of a postoperative empyema. In seven of the remaining eight, a patent shunt has protected the patients from further hemorrhage for from two to six years.

Conclusion

In so small a series of cases, mortality figures are meaningless, but with the proper selection of patients it seems that it should be feasible to perform this procedure with an acceptable mortality of around ten per cent. To date, our experience confirms the general opinion that a successful shunt will protect a patient from further gastrointestinal hemorrhage due to portal hypertension, whether of the intrahepatic or extrahepatic type.

Summario in Interlingua

Circuir un obstruite vena portal per le effectuation de un shunt via le sinistre vena renal o directemente in le vena cave constitue in seligite casos de varices esophagee con hemorrhagia un efficacissime mesura pro le prevention de hemorrhagias additional. Le mortalitate in le operation amonta a circa dece pro cento. Es reportate un serie de dece casos, incluse duo con successo mortal.

[13] Hallenbeck, G. A., and Shocket, E.: An evaluation of portocaval shunts for portal hypertension. Surg. Gyn. Obst. 105:49, 1957.

Tuberculin testing, after nearly 30 years of disuse, has again become a valuable casefinding tool in the tuberculosis prevention program

The Significance and Potentialities of the Tuberculin Test

ROBERT H. MARKS, M.D.,* Honolulu

DURING THE past three or four years approximately 50,000 tuberculin tests have been given each year in the tuberculosis control program of Hawaii, plus an increasing number given by private physicians, especially pediatricians and obstetricians.

Many of us here remember when the tuberculin test, extensively used in the schools in the 1930's, was eventually abandoned as a mass casefinding measure in the tuberculosis control program. It even lost its interest as a diagnostic measure because at that time most young adults were positive. It did not seem necessary to give a tuberculin test to an adult in order to rule out tuberculosis since so many of them had a strongly positive reaction anyway. Also, such a tuberculin testing program in the primary schools found very few cases of tuberculosis in the children tested. Tuberculosis in a chronic form, especially pulmonary tuberculosis, has always had a low prevalence in children between the ages of five and twelve.

* Chief, Bureau of Tuberculosis, Department of Health, State of Hawaii.

Read before the 103d Annual Meeting of the Hawaii Medical Association, Hilo, April 24, 1959.

Tuberculin Reactors Used to be Commonplace

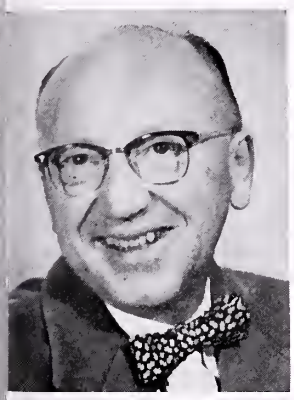
In those days it was impractical to attempt to go into the homes of those children who were positive to try to find their source of infection as we do now with convertors and the younger children. Too many of the children were positive to make this economically feasible, and x-ray examinations of all members of the families of these positive reactors would have been inordinately expensive if not impossible at that time. In those days we lived in such a tuberculous milieu that tuberculous infection was almost universal by the time the person reached adult life. Thus it was that the tuberculin test fell into unfortunate disuse.

Why, then, this present interest in the use of the tuberculin test? During recent years it has gradually dawned on us that with the change in the prevalence of tuberculosis, the tuberculin test now has a comparatively greater significance and is an important casefinding as well as diagnostic tool. Only four or five per cent of elementary school children and 10 to 15 per cent of high

school students now react positively to the test; and it is estimated that the average prevalence of positive reactions in the adult population here would be somewhere between 30 and 40 per cent, increasing with the mean age of the population under study.

Oahu Children Being Studied

Our experience with the tuberculin test during the past few years has given us knowledge not only about the prevalence of tuberculous infection in Hawaii but also regarding the test itself. The largest tuberculin testing program in the islands now is that in the school children in western Honolulu carried out by the Oahu Tuberculosis and Health Association in cooperation with the Health Department and the Department of Public Instruction. In this particular project, which has been going on for four years and has one more year to run, each child upon whom we have obtained parents' consent is tested yearly regardless of whether his test was positive the year before, except in those rare instances of a marked reaction. In this particular study attempts are made to obtain x-rays not only on the children who are considered to have a positive reaction but also to try to find the source of their infection by examining their close associates.



DR. MARKS

This project on Oahu was set up to determine how extensively the tuberculin test should be used in the schools as a public health measure for tuberculosis control, and to find out whether unknown cases of tuberculosis can be found by using this test on a large scale and searching for the sources of those with positive reactions. Also, by relating the size and type of reaction to the cases found, we are attempting to find a clue to the meaning of the variations in size of the reaction.

When the tuberculin test is truly positive—when it is a marked reaction, or when it persists on a retest—it means that that individual has been infected with the tubercle bacillus. If the person with a positive reaction eventually develops clinical tuberculosis he has had either: (1) a breakdown (or progressive continuation) of the original focus of infection; or (2) an infection from without—a superinfection. In our population here we believe that a majority of the new cases are the breakdown of those original foci of infection which are often many years old. The tests in our high schools show that 85 to 95 per cent of the children are now graduating from high school with a negative tuberculin reaction. This is quite the reverse of what it was 30 years ago when almost 80 per cent of high school graduates were positive.

Positive Tests Now Suggest Recent Infection

Thus it is becoming increasingly obvious that the opportunity for infection now is so slight that as long as preventive measures are maintained, tuberculosis will be found chiefly among those people who have been infected in the past. We believe that this is already true in Hawaii. This is illustrated by the following example. Recently a high school student on Oahu was found to have advanced pulmonary tuberculosis with cavitation and positive bacteriological findings. Her tuberculin test while in the seventh grade three years before was positive, although her x-ray then was clear. It is the person with the positive tuberculin test, regardless of age, who needs routine chest x-rays. In other words, negative reactors—who have escaped the infection up to this time—have a decreasing opportunity of being infected, and hence a diminishing chance of developing the disease. Tuberculosis as a disease will crop up in those of us who have a positive tuberculin test—those who have been already infected.

Furthermore, if there has been a recent change from a negative to a positive tuberculin reaction, we know that at some time during the interval between tests, this individual has been in contact with someone with active tuberculosis, or at least has had some access to the tubercle bacillus. In such a case it would therefore be the responsibility of the physician (whether he be in public health, industry, or private practice) who has found such a conversion, not only to consider how best to prevent clinical disease in that person, but also to endeavor to find the source of his infection. This is especially true in children who most likely would have received their infection from within the family circle.

Illustrative Cases

The following cases illustrate the value of the tuberculin test as a casefinding measure and bring out some of the difficulties involved in tuberculosis control.

CASE 1.—A 12-year-old girl was found with a strongly positive tuberculin test when the students of an intermediate school were tested. In examining the six adult members of this child's family, we found the father (who, by the way, had never previously had an x-ray)

to have moderately advanced active tuberculosis with sputum positive on smear and culture.

There was an interesting sidelight to this particular case. He had held a responsible job for several years in the office of a well-known local company. When told about his tuberculosis, he expressed concern that if he had to go to the hospital he would lose his job. He said that his family would not be able to manage without his earnings. As is our policy, he was referred with our recommendations to his private physician. When we did not hear anything further from him or his physician, we called the doctor and learned that he had started treatment on an ambulatory basis. The doctor was told that because of the patient's heavily positive sputum he should not be allowed to work because of danger to his associates. The physician became very angry and complained that we were not recognizing the "humane" aspect and the personal hardship involved, as the patient would lose his job by going to the hospital. We told the doctor that most employers do not take that harsh an attitude in this day and age, and that it was not likely that his job would be lost, but that in any case the people in his office would be severely exposed if he stayed on the job.

The patient was therefore seen again and accepted the necessity of hospitalization. The employer allowed the man sick leave with 60 per cent of his pay for the whole period he was away from work and promised his job would be held for him. The man entered the hospital in April, 1958, and he is now about ready to be discharged, being already on a work therapy schedule of six hours a day with his former employer. He will have to continue with his chemotherapy for several months or years on an ambulatory basis.*

CASE 2.—The next case was discovered because of finding a positive tuberculin test in his son, age 12. The patient was a 45-year-old man of Chinese descent. The x-ray showed bilateral moderately advanced tuberculosis. This man had had previous x-rays, all negative. Survey x-rays two and a half years before were negative and he also stated that he had had x-rays in the place in which he worked, less than a year before the diagnosis. He was referred to the hospital where admission sputum and one subsequent gastric lavage were positive on culture. Note that this man was 45, and that less than a year before he presumably had a negative x-ray. This individual, like the previous one, had lived for many years in the Orient, where tuberculous infection is still almost universal, and had returned here within the past ten years.

CASE 3.—A seven-year-old boy was found with a strongly positive tuberculin test. An x-ray on his mother, a part-Hawaiian woman, revealed a minimal lesion which was considered to be probably active and it was recommended that she go to the hospital. Sputum was positive on one admission specimen in June, 1958. She is about to be discharged and will continue her treatment for another few months after discharge.† This woman had six children, and one other child of pre-school age was found with a positive tuberculin test and is receiving prophylactic treatment in a special clinic set up for this purpose at Leahi Hospital.

CASE 4.—The next case is interesting in that it shows the difficulties encountered in tracing the source of an infection and in being sure that, having found one presumed source, we have not overlooked another. It also demonstrates the inadequacy of depending only on x-rays without adequate laboratory tests in determining the activity status of a given case.

The Health Department had tuberculin tested in 1954 three children ages eight, seven, and two as contacts of a young uncle found in an x-ray survey with active tuberculosis. They were followed with repeated negative mantoux for the usual period after the contact was broken by his admission to Leahi. In 1957 the middle one of the three had a strongly positive reaction to the PPD done in the school testing program and was started on chemotherapy. Up to that time a grandfather living in the home had been followed as an inactive case of tuberculosis with activity status established by x-rays only. When the child converted, the grandfather's doctor was asked to send him in for tracheal lavages. These were positive on smear and culture. He was admitted to Leahi in December, 1957, and is still positive despite treatment. The oldest of the three children was later reported to have a marginally positive mantoux also and referred to Leahi Special Clinic for evaluation. Unfortunately, in this situation, the children served as guinea pigs because of inadequate supervision of a known case. The breakdown of the inactive case was discovered by infection of the grandchild, rather than by the careful routine examination of the patient himself.

An Effective Measure

The work involved in tracing the source is often tremendous. One source investigation involved 17 people over 16 years of age, finding three new active cases; a grandmother, an aunt, and a tenement neighbor. All were hospitalized.

We are convinced that tuberculin testing of selected groups including children, students, prenatal patients, certain industrial groups, and persons reporting to their physicians for medical care takes its place along with the x-ray as a diagnostic measure and as an important tool for tuberculosis eradication.

Summario in Interlingua

Trenta annos retro, reactiones positive al injection de tuberculina esseva si commun in Hawai que le test habeva nulle valor in le detection de nove casos o como mesura epidemiologic. Isto ha cessate esser ver. Hodie non plus que cinque pro cento del scholares in le scholas elementari o dece a dece-cinque pro cento del scholares in le scholas secundari de Hawai reage positivemente a tuberculina. Le test es assi un preciose mesura pro le detection de casos e indica frequentemente le presentia de un infection o superinfection recente. In le insula de Oahu, un extense programma del uso del test es nunc in le quarte (de cinque) annos.

* The patient has since been discharged from the hospital with approval to resume full time work.

† Patient has since been discharged from the hospital and is continuing on chemotherapy in their outpatient department.

The President's Page



Bauer

DR. NISHIGAYA

There is, and will be, continuing emphasis on the care of the aged (over 65), and disabled individuals.

Since President Eisenhower's announcement of the White House Conference for January, 1961, mounting interest is being evidenced throughout the country. Top level personnel in government and many community leaders have been expressing increasing concern over the over-all care of these people.

At The First National Conference of the Joint Council to Improve the Health and Care of the Aged held in Washington, D. C., Congressman John E. Fogarty of Rhode Island expressed the feelings of many members of Congress when he posed Federal legislation and intervention if the states and citizenry failed to cope with the problem.

Grave concern was expressed by both Federal and California public health officials, who were co-sponsors at a recent Rehabilitation Institute held at the Rancho Los Amigos Hospital in Los Angeles.

The problem is a community project but national in scope and federal as well as local agencies should cooperate. However, the role of the medical profession as leaders in this crusade is recognized. Much emphasis on early prevention of devastating disabilities as well as the physician's responsibility in the management of the aged and disabled was stressed.

Hawaii and the medical profession in general have much to be proud of. We are far more advanced in our preparation for the care of these unfortunate people than many areas in the Western United States. Many at the Institute were impressed with Hawaii's Rehabilitation Program—the center, its functions, and the educational projects we have. It was with great pride that the delegates from Hawaii could discuss the plans and programs that were being outlined for areas devoid of such facilities.

In January 1960, a local rehabilitation institute will be sponsored by Governor Quinn and the local Department of Health. Top level consultants in the field of Rehabilitation will be brought in from the Mainland. These include Dr. Leon Lewis, Director, Respiratory and Rehabilitation Center, Fairmont Hospital, San Leandro, California; Dr. David Frost, Regional Medical Consultant, Office of Vocational Rehabilitation, San Francisco; Dr. Charles R. Hayman, consultant U. S. Public Health Service, as well as trained physical and occupational therapists, a social worker, and a nurse.

Dr. Lewis is an excellent and forceful speaker, dedicated to his work, and should prove worth listening to.

A fine informative program which has taken many hours of planning is being offered to the profession and paramedical personnel in Hawaii. All are urged to attend. The entire State will be covered, as neighbor island visits are planned.

T. Nishigaya, M.D.

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[EDITORIALS]

Honest Medical Advertising

American medical publications, with few exceptions, take pride in the highest standards of medical advertising in the world. Their pages are not available to advertise just any medical product, but only honest and ethical items about which only honest and ethical claims are made.

The American Medical Association, through the J.A.M.A., has taken the lead over the years in bringing this situation about. State association journals have gradually fallen into line, and the three dozen or so of them whose national advertising is obtained through the State Journal Advertising Bureau, as well as the few who remain independent, now have as high standards as those of the A.M.A. itself.

John Lear, Science Editor of the *Saturday Review,* alluded in their issue of September 5 to "the recently inaugurated *Medical Letter,* which gets all of its sustenance from and pays all of its loyalty to its doctor-readers." Mr. Lear must be thinking of newspapers, which cannot offend their advertisers and still stay solvent; or perhaps of lay magazines, which are in the same position. This medical journal regards its responsibility to its advertisers as fully discharged by publishing their advertisements, and we suspect that most medical journals have this attitude. To refrain from proper criticism for fear of losing an advertising contract would be grossly unethical on the part of a medical editor.

Mr. Lear caught Pfizer a year or so ago in the act of publishing an ad for Sigmamycin embellished with the professional calling cards of eight physicians who approved of this antibiotic, by implication, and used it. Mr. Lear found that the eight doctors were all imaginary. The Federal Trade Commission has charged Pfizer with misleading advertising, and is still deciding whether or not to issue a "consent decree."

Now Mr. Lear alleges that Roerig, a Pfizer subsidiary, has advertised clinical experience with Daricon (oxyphencyclamine, an antispasmodic) as if it were experience with Enarax (Daricon plus Atarax). He says that their Medical Director, Dr. Martin Seidell, resigned in protest over the incident.

If these allegations are true, we would agree with Mr. Lear that they are damaging. We would not defend such a practice. We would agree that it is a reflection upon the pharmaceutical industry.

This incident does not reflect, however, upon medical journal advertising. Neither of the advertisements Mr. Lear criticizes was published in a medical journal. Mr. Lear's suggestion that the dependence of medical journals upon pharmaceutical advertising might lead them to connive at such practices is unfounded, so far as this or any other state medical journal is concerned.

We believe all the advertisements we publish are ethical and honest—including the Roerig and Pfizer advertisements. We try to publish no other kind. And it is to the credit of the pharmaceutical industry that we have not yet, so far as we know, been offered any other kind.

Newer Concepts in Virology

The dividing line between living organisms and nonliving organic material is a very hazy zone occupied by the viruses. No satisfactory definition of a virus has yet been made. Recent findings tend to make a definition of a virus even more difficult. The smallest and simplest viruses consist of a nucleoprotein, and the single infectious unit is a single molecule. These viruses contain no independent enzyme systems that can be detected by any known biochemical methods. Apart from their host cell they appear as inert material, and in some instances such as polio, coxsackie, and tobacco mosaic, viruses have even been concentrated and purified until they appear in a crystalline form. Polio virus has been separated into its protein and nucleic acid components, and it has been demonstrated that the nucleic acid fraction alone can infect a suitable host cell. From the host cell the protein portion is obtained and incorporated with the nucleic acid, and fully formed virus is then eventually released.

Different strains of tobacco mosaic virus have been "hybridized" by mixing the appropriate nucleic acid and protein fractions. However, it has not yet been possible to combine artificial nucleotide polymers with natural virus protein and obtain an infectious preparation.

The demonstration of the ability of the nucleic acid fraction of a virus to utilize protein from the host cell now explains why purification of animal viruses may result in preparations having some immunochemical properties of the host and therefore being considered contaminated with extraneous protein. This was one of the major obstacles to the acceptance of the theory of viral etiology of certain tumors, since these viruses are often almost antigenically identical to the respective normal host tissue.

The ability to manipulate viruses on the chemical level offers many intriguing possibilities; among other things, for the production at will of strains possessing certain desired properties such as low virulence combined with high antigenicity, or broadened antigenic properties so that greatly improved vaccines can be prepared.

ROBERT E. KISSLING, D.V.M.
Virologist, Bureau of Laboratories
Hawaii State Department of Health

Virus Laboratory Service Available

The Bureau of Laboratories of our Department of Health is now prepared to offer assistance in the diagnosis of the more important and common virus diseases for which laboratory tests are presently available. The primary techniques being employed are serologic tests to determine changes in antibody titers, and isolation of viral agents.

Specimens for virus isolation should be collected during the first three days of a disease. They must be frozen immediately after collection. Sterile nutrient broth and other protein-containing material or sterile distilled water may be used for collection of throat or nasal washings. Do not use saline solutions, since salt ions are detrimental to viruses in the absence of protein.

Throat swabs and rectal swabs should be placed in tubes containing broth or distilled water and promptly frozen.

Feces, scrapings of skin lesions, spinal fluid, blood serum, sputum, and biopsy or autopsy materials should be placed in sterile containers and *frozen immediately*.

Specimens for serologic tests should *not* be frozen. Two serum specimens are needed—the first taken during the first two days and the second 10 to 21 days after the onset of disease. Only a rise in antibody titer may be taken as evidence of current infection with a particular virus. The blood should be collected with a sterile syringe and needle and placed in a sterile tube.

Specimens may be taken directly to the Virus Laboratory at Hale Mohalu in Pearl City or left at the main Board of Health Laboratory in Honolulu.

Information regarding collection or submission of specimens for virus examination may be obtained by calling Dr. R. E. Kissling, phone 452-223, Honolulu.

Infant Death Case Studies

A 5-pound boy was born at 33 weeks' gestation, of a diabetic father and mother. The mother, age 42, was gravida 7, para 4, abortus 2. Serology was negative, and Rh positive. The mother was a known diabetic with "good control" on a 2000 calorie diet. She was given Delalutin, 1 cc every five to seven days until the end of the eighth month. She had mild contractions during the first trimester. Membranes ruptured 10½ hours before delivery; the baby was an LOA presentation; labor lasted 10 hours. The infant was delivered spontaneously and easily with no anesthesia; analgesia consisted of a few whiffs of Trilene. Distress was noted immediately after delivery. Spontaneous respirations were poor, and the patient was placed in an incubator with oxygen. The patient was kept alive for the next 41½ hours with artificial respiration through an endotracheal catheter. On autopsy the heart was normal. Lungs showed bilateral atelectasis (right more than left), with no evidence of hyaline membrane disease.

Discussion: Consensus of Committee was that though the infant appeared mature according to weight, actually he was quite immature. Questions raised which were not answered in the case description by the attending physician were: duration of maternal diabetes and description of recent pregnancies.

Classification: This was considered a pediatric death, not preventable.

* * *

An infant was delivered of an 31-year-old gravida 8, para 6, abortus 1, blood group A, Rh negative mother. Because of the history of previous severely affected infants, two requiring exchange transfusions and one thought to be an erythroblastotic stillbirth, induction was attempted approximately six weeks prior to the expected date of confinement. The titer studies during the mother's pregnancy did not indicate a definite rise but the maternal Coombs test was positive. At birth the infant was edematous, not breathing and had a firm pulse of 130. The liver was markedly enlarged, and an enlarged spleen was present. After ten minutes of resuscitation, the child began to breathe on his own, though weakly. General appearance was very poor. Exchange transfusion was started almost immediately. Pressure in the umbilical vein was noted to be extremely high. Sixty cc of blood was removed before any was replaced and the venous pressure dropped considerably. A total of 475 cc of blood was given and 497 removed. Five cc of calcium gluconate was administered during the course of the transfusion. The general condition improved considerably, though moist rales continued in the lungs; liver size decreased markedly. The infant was digitalized with 0.12 mg of Cedilanid intramuscularly in two doses over a two-hour period. The patient became apneic 11 hours after birth with bradycardia responding only temporarily to adenaline and expired 17½ hours after birth.

Laboratory data: Cord blood O, Rh positive, Coombs positive, hemoglobin 2.8 and hematocrit 18. The plasma was icteric. Ninety per cent of the red blood cells were nucleated. Post exchange bilirubin was 5.25 mg per cent, hemoglobin 10.5, and hematocrit rose to 33. Two hours before death the bilirubin was 9 mg, hemoglobin 8.5, and hematocrit 30. Autopsy: Gross findings were an enlarged heart, severe bilateral pulmonary edema, splenomegaly, and hepatomegaly. Microscopically the lungs showed marked edema and hyaline membrane formation in many of the alveoli.

Discussion: A catheter introduced into the umbilical vein when the cord is tied facilitates lowering of recurrent increased venous pressure. Steroids for the mother have not shown positive results in the baby. The best time to induce labor for the individual patient should be discussed between obstetrician and pediatrician.

Classification: Theoretically this is a preventable pediatric death. However, very few babies with this severe form of erythroblastosis have recovered, regardless of treatment.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

This is What's New!

Bone marrow transplant from a normal **identical twin** to the twin affected with **acute leukemia** has recently been carried out. The transplant was preceded by 255 tissue roentgens. This dose was sufficient to destroy all blastic cells, but probably was insufficient to alter the antibody response. The results were not striking. Within eight weeks a leukemic relapse occurred and within eight months the leukemic twin was dead. This would indicate that under these conditions, an isologous marrow graft has no advantage over the homologous marrow graft; in fact, the homologous graft may offer better results in the control of leukemia. (*Blood* [Mar.] 1959.)

Severe **hypertension** was found to be a very rare late complication of **toxemia of pregnancy.** However, it does cause, on the average, an increase in the blood pressure of women studied four years after the toxemia. (*Brit. Med. J.* [Saturday, Aug. 15] 1959.)

Antiseptic solutions may not be antiseptic. Such solutions as **Cetrimid** and **Zephiran** may contain viable bacteria such as **Pseudomonas.** Serious infections and even death have resulted from their use. (*A.M.A. Arch. Int. Med.* [July] 1959.)

Crisis in Britain! The British Medical Association has stopped issuing its booklet, "Getting Married." Dr. deKok, the Editor, resigned from the B.M.A. in protest. "All we did," said Dr. deKok, "was to state the facts. We wanted to help all young people instead of only the good ones." (*J.A.M.A.* [May 9] 1959.)

Wilder Penfield, who knows more than a little about the human brain, describes a **"playback" area** in both **temporal lobes.** Electrical stimulation of these temporal areas produces more than mere remembrance of things past. The conscious patient so stimulated actually hears music playing, not merely remembers a certain tune.

This type of response has not been produced in other areas of the cerebral cortex; for example, stimulation of the visual sensory area causes a person to see flashes of light but never a recognizable person. Likewise, stimulation of the auditory sensory cortex may cause one to hear various sounds, such as ringing, buzzing, etc., but never recognizable voices.

This "interpretive" cortex of the temporal lobes, then, has something to do with the mechanism that reactivates recall of past events, and brings them to the present consciousness. This is not just memory, for destruction of the temporal lobes does not destroy memory. The temporal lobes do, however, have access to those areas in the brain where memory is stored. (*Science* [June 26] 1959.)

In an excellent review, two Californians outline the facts that support a more precise description of the anatomy of body water and electrolytes. Most important is the awareness that **extracellular fluid** is **not homogeneous.** The extracellular water and electrolyte concentrations vary considerably from organ to organ, especially from dense tissue such as bone to loose interstitial tissue. This extracellular heterogeneity explains the discrepancy between results obtained by newer tracer dilution techniques and those found by older measurements of extracellular fluid volume. (*Am. J. Med.* [Aug.] 1959.)

Wintrobe's group in Salt Lake City report longer survival in **acute leukemia** coming under treatment since 1954. The median **survival time** of all cases of acute leukemia treated since 1954 has been **doubled.** This is really not too encouraging because it merely means an increase in life span from three to six months. Treatment of myeloblastic leukemia is most discouraging, with almost all types of chemotherapy being ineffective. With lymphoblastic leukemia, in children at least, the picture is brighter. Half of the children with initial white counts of less than 10,000 survived more than 12 months. A good part of this longer survival is attributed to the use of double or triple therapy, such as 6-mercaptopurine being used in conjunction with corticosteroids or some other chemotherapeutic agent. (*Blood, J. Hematology* [July] 1959.)

In Kansas City, a 72-year-old woman ate 12 persimmons. The persimmons formed a **phytobezoar.** The phytobezoar in turn resulted in the appearance of cramping upper abdominal pain, three upper G. I. series, and six doctors (one doctor for every two persimmons). The lady got well after being fed **papain** and **sodium bicarbonate** powder every three hours. The problem was then properly taken to the laboratory. Here basic *in vitro* studies were set up but unfortunately the persimmon season came to an end before the experiments were completed. (*A.M.A. Arch. Int. Med.* [Apr.] 1959.)

FRED I. GILBERT, JR., M.D.

Book Reviews

Introduction to Clinical Endocrinology

By A. Stuart Mason, M.A., M.D., B.Ch. (Cantab.), M.R.C.S. (Eng.), M.R.C.P. (Lond.), 192 pp., $4.50, Charles C. Thomas, 1957

As intended by the author, the material presented in this concise volume serves as an introduction to the field of clinical endocrinology. However, the presentation is well organized, and the subject matter is treated clearly and briefly. Controversial viewpoints have been reduced to a minimum, and therefore, a tendency towards oversimplification pervades the text.

However, though the author defines his purpose in writing this book as providing a brief survey of clinical endocrinology for the senior medical student, and general practitioner, it serves the internist well as a "quick" reference source.

RALPH BEDDOW, M.D.

Cyclopropane Anesthesia, 2d Ed.

By Benjamin Howard Robbins, B.A., M.S., M.D., 293 pp. $9.00, The Williams and Wilkins Company, 1958.

This second edition follows the original by eighteen years. It performs the admirable service of collecting and organizing information found in hundreds of experiments, observations, and research programs in such a way that the reader can use this material to his best advantage in numerous ways. It is an excellent text for anesthesiologists. It is a good reference work with excellent index and logical organization, and the bibliography of 353 references indicates the wide basis for the facts and opinions to be found therein. It is clearly written and the text is amply supplemented by a large variety of illustrations, tables, and reproductions of graphic recordings.

I would not recommend this as a book for casual reading, but concise summaries at the end of nearly each chapter or section enable one to gather quickly a valuable amount of information in a minimum of time and effort. Cyclopropane, as the most satisfactory inhalation anesthetic agent at the present time, fully justifies the book.

CARL E. JOHNSEN, JR., M.D.

Communicable Diseases, Vol. IV

Editor in Chief, Colonel John Boyd Coates, Jr., M.C., 544 pp., $5.50, Office of the Surgeon General, Department of the Army, 1958.

This is an extensive and complete statistical study of communicable diseases in the Army during World War II. Little or no space is given to either diagnosis or treatment, thus limiting the interest in this book to dedicated, lifetime members of the Army Medical Corps.

F. D. NANCE, M.D.

Introduction to Anesthesia

By Robert D. Dripps, M.D., James E. Eckenhoff, M.D., and LeRoy D. Vandam, M.D., 266 pp., $4.75, W. B. Saunders Company, 1957.

This textbook is intended primarily for beginning students of anesthesia. It gives very detailed instructions for the management and techniques of administering various types of anesthesia, yet it is very basically written. It does not cover advanced types of anesthesia, as hypothermia and hypotensive anesthesia. It is not advanced enough to be of much value to the anesthesiologist or as a reference book for other physicians. It is excellent for a beginner in anesthesia or for one wishing to become familiar with the general field of anesthesia.

HELEN WALLACE, M.D.

★ Highly recommended.

Also Received

The Medical Clinics of North America, Vol. 43, No. 4

Consulting Editors Max P. Lipman, M.D., and David State, M.D., pp. 969-1271, July, 1959.

The Los Angeles number on medical considerations in surgical disease covers a wide variety of subjects including medical treatment of cancer, medical and surgical aspects of portal hypertension, and anesthesia in obstetrics.

That the Patient May Know

By Harry F. Dowling, M. D., Sc.D., Tom Jones, B.F.A., 139 pp., $7.50, W. B. Saunders Company, 1959.

Diagrams, charts, and simple explanations of everything you might want help in explaining to your patient. More, sometimes, than the patient would want to know.

★Preventive Medicine

By Herman E. Hilleboe, M.D., Granville W. Larimore, M.D., 731 pp., $12.00, W. B. Saunders Company, 1959.

A concise, clear, orderly presentation of preventive medicine in all its aspects, from accident prevention to fluoridation and disaster defense.

A Primer of Water, Electrolyte and Acid-Base Syndromes

By Emanuel Goldberger, M.D., F.A.C.P., 333 pp., $6.00, Lea & Febiger. 1959.

Another! It steers a middle course between the overly mathematical and overly chemical treatises, with a strong clinical slant.

Autogenic Training

By Johannes H. Schultz, M.D., Wolfgang Luthe, M.D., 289 pp., $9.50, Grune & Stratton, 1959.

A practical treatise on a kind of occidental yoga—impressive if your orientation is this way, a little hard to swallow if it isn't.

★Hypertension

Edited by John H. Moyer, M.D., 790 pp., $14.00, W. B. Saunders Company, 1959.

Ninety-one contributors, and 98 presentations and panel discussions, on high blood pressure. The discussions, as usual, are the best part. As good as a mainland trip—and not nearly as expensive.

In Memoriam -- Doctors of Hawaii -- XXIII

This is the twenty-third installment of In Memoriam—Doctors of Hawaii.

Minnette Burnham

Minnette Burnham was born in Illinois on January 16, 1868. She graduated from the Woman's Medical College of Pennsylvania, Philadelphia, in 1899.

For many years Dr. Burnham served as a medical missionary in China. Coming to Honolulu in 1905, she was head of the old Chinese Hospital. When that institution closed, she entered private practice.

Dr. Burnham died April 4, 1943, in Honolulu at the age of 75.

Charles Bailey Greenfield

Charles Bailey Greenfield was born January 18, 1844, in Monmouthshire, England, the son of James and Margaret Greenfield.

It is not known where he received his early education, other than that he was sent away to "public" boarding school at the tender age of six, as was the custom among well-to-do English families of that day.



DR. GREENFIELD

In 1861 he entered King's College, London, to begin the study of medicine. In 1864 he received his degree and then served at King's College Hospital, where he was considered "a most industrious pupil." It is interesting to read old letters which attest to his being "a person of moral recttitude and professional attainment."

Dr. Greenfield's graduate work was done at the Royal College of Surgeons of England, London, and at the University of Edinburgh.

From 1865 to 1866 he served at the Royal Hospital at Plymouth where "his general conduct was such as to merit approbation."

In 1866 Dr. Greenfield was appointed medical officer to the HMS "Topaze." Cruises on the "Topaze" offered him the opportunity to see much of the world, particularly the islands of the South Pacific and the countries of South America. He kept detailed diaries of his many voyages and on one such voyage his ship touched at Easter Island. Having made friends with the natives, they offered to show him great stone ruins, which they said had never been seen by any white man. It is interesting to realize that Dr. Greenfield may well have been the first white man ever to see the now famous stone images of Easter Island.

During their cruises to South America, Dr. Greenfield became fascinated by this great continent and wished to see more of it. In 1871 he was given leave from the navy and set out for Lima, Peru, where he had previously made friends among the English colony.

Coincident with his visit there was an outbreak of the dread yellow fever, which soon reached epidemic proportions. Dr. Greenfield immediately volunteered his services, which were gratefully accepted by the government. With the help of one faithful Catholic priest, he worked day and night caring for the sick and dying.

The morning of Good Friday dawned. It was known for years after in Lima as Black Friday. On that day alone 400 people died, and Dr. Greenfield and the priest were the only souls stirring in the city. But the epidemic had reached its peak; and thanks to the selfless work of this wonderful man, the epidemic was brought under control. As a result of his heroic work, Dr. Greenfield received two letters of commendation—one from Her Majesty's government signed by Earl Granville, the other from the Peruvian government. Both expressed gratitude for his heroism and unselfish devotion to duty.

On May 5, 1875, Dr. Greenfield was married in London to Frances Watson, who was to prove a tower of strength to him from that time on, and a woman equal to the difficult task of being a doctor's wife. Feeling that the navy was no life for a married man, he resigned his commission; and he and his young bride moved to California. Here were born his three eldest children, Theodore, Francis, and Margaret.

In 1880 an old friend in Honolulu, General Soper, wrote telling him of the need for a government physician on the island of Hawaii. Dr. Greenfield came.

It was a grueling job at best—as government physician he was responsible for the entire Hamakua District, up to and including Waimea and Waipio Valley—and this all by horse and buggy, or on horseback, over ofttimes nearly impassable trails. He was also doctor for two of the plantations in the district. Surgery, confinements, broken bones—all were within his province. In addition Dr. Greenfield prepared all his own pills and medicine—all these tasks with only the help of his loyal wife and older sons.

While on Hawaii Dr. Greenfield's other children were born, Walter, Frances, Vere, and Louise. All seven were personally educated in their early years by Dr. and Mrs. Greenfield.

At a time when life was primitive and rough, the Greenfield home was the moral, social, and spiritual center of the community. Church services, baptisms, and weddings were only some of the activities that took place in their home. And any new arrival from the "old country" was automatically sent to the Greenfields where he or she was assured of a warm welcome and a place to stay.

If ever a man typified the highest ideals of medicine, that man was Dr. Greenfield. Beloved by all who knew him, he was unfailingly kind and gentle and humane. But for a man with a bad heart, the years of arduous labor were bound to take their toll. On January 25, 1907, at the age of 63, Dr. Greenfield died.

A fitting obituary for this dedicated man can be found in this quotation from a letter from L. E. Pinkham, President of the Board of Health and later to become Governor of Hawaii. "Dr. Greenfield's reputation as a physician was supplemented by that of gentleman and host. The graces of life as well as the duties were personified in him and his family."

Dr. Greenfield is survived by two of his daughters, Mrs. Cecil Tompkins of Kent, England, and Mrs. John Grace of San Rafael, California, as well as by a number of grandchildren and great-grandchildren.

PATRICIA ROGERS PRUKOP, *Granddaughter*

BY PUBLIC APPROVAL

Arthur W. Page, former vice president of American Telephone and Telegraph Co., once said: "Business in a democratic country begins with public permission and exists *by public approval!*" In the past, this fact has been solidly demonstrated by the tremendous public acceptance and response to the economic assistance offered by voluntary non-profit community service prepayment plans for health care such as HMSA.

Another factor for HMSA's success, and other plans like it, is that Americans, by and large, prefer to solve their own problems by private initiative and private enterprise, rather than by government intervention. The result of great public interest and serious private enterprise through the years is HMSA's present statewide program, supplemented by an expanded effort by the insurance industry in this field. Both HMSA and the commercial insurance programs are based upon the traditional pattern of free choice of physician, fee-for-service, and the private relationship of patient and doctor.

Today, however, the people of Hawaii are being urged to accept medical care offered by a "closed panel" program. The AMA has acknowledged the right of the patient to choose not only his own physician, but also the pattern or group plan through which he wishes to prepay his medical care. HMSA's Participating Physicians *must realize* that ultimately they can preserve their traditional pattern of medical service *only* if their patients find that it meets their vital needs better than any other program. *Your patients must not only approve of your services . . . but also the prepayment plan through which they can obtain your services . . . if they are to remain your patients!*



HAWAII MEDICAL SERVICE ASSOCIATION

Blue Shield Plan for Hawaii

Member, Western Conference of Prepaid Medical Service Plans
HONOLULU . . . 1154 Bishop St.—Phone 66-151
HILO . . . P. O. Box 1356—Phone 51-855
WAILUKU . . . P. O. Box 256—Phone 323-912
LIHUE . . . P. O. Box 27—Phone 22-201

Bureau of Medical Economics

AUTOMATION ENTERS MD'S OFFICE

A few months ago, in a continuing effort to be of valuable assistance to the doctors of Hawaii, the Bureau introduced a system of bookkeeping using electronics. Unfortunately there were certain weaknesses in this system which were not evident in the beginning. Because of these weaknesses the system did not produce satisfactory results so it was temporarily discontinued.

With a firm belief that this method of bookkeeping is sound and practical for doctors, the Bureau continued to investigate and study various related methods and equipment. Working with specialists in this field, our efforts have been rewarded.

The Bureau is pleased to direct your attention to the October 5 issue of the AMA News. In this issue, page 14, there is a testimonial by a Doctor L. Q. Logan, of Bakersfield, California, which describes an Electronic Bookkeeping System designed especially for doctors. Dr. Logan outlines the many advantages and benefits of such a system to him and to all doctors.

We respectfully direct your attention to page 3 of the last issue, or to page 208 of this issue, of the HAWAII MEDICAL JOURNAL for an interesting and informative advertisement by the manufacturer of this equipment.

Basically these results are what the Bureau endeavored to gain when it introduced Electronic Bookkeeping to the doctors of Hawaii.

There were two important disadvantages of the previous BME system which have been overcome in the system used by Dr. Logan.

These are:

1. The patient's itemized, up-to-date record and balance are retained at all times in the doctor's office.
2. The accounts are proven to be correct before being sent to the Service Bureau for processing.

Through the use of a small bookkeeping machine and an electronic device the doctor's office is able to capture all patient financial data on a punched paper tape. This tape agrees with the doctor's printed records and no other manual handling of the figure work is required by the Service Bureau* using electronic equipment for the processing of the statements and related records.

In the previous BME system the doctor's aide submitted a hand, or typewritten, list of all charges and credits to the Bureau. These records then had to be manually "Key-punched" to produce the means for obtaining the doctor's statements to his patients.

In discussing this system with National Cash Register's Medical Bookkeeping Specialist, here in Hawaii, the Bureau has learned that this Company has been of a great deal of service to the medical profession, both on the mainland and here in Hawaii. For example, there is no charge to the doctor for getting his accounts in balance prior to the installation of such equipment. Thorough training by an expert in this field is part of the service at no additional cost to the doctor. These services alone can be worth the cost of the equipment.

This system has been on display and demonstrated to doctors at several recent medical conventions on the mainland. It has been proven to be of valuable assistance to the doctors and is being enthusiastically accepted by them all over the United States, and here in Hawaii.

Convention showings:

American Academy of General Practice, San Francisco, April 1959.

Academy of Osteopathic College of Proctology, Kansas City, Kansas, April 1959.

American Medical Association, Atlantic City, New Jersey, June 1959.

Hawaii Medical Association Annual Meeting, May, 1958.

Advantages of Machine Posting

The following are the principal advantages of machine posting for a doctor:

1. Facility to automatically add, subtract, figure balances and accumulate a total while producing bookkeeping records.
2. Facility to record routine entries faster, more accurately, more legibly, and therefore more economically.
3. Facility to post entries on two or more related records simultaneously.
4. Facility to enforce an accurate record of transactions where the handling of cash is involved.
5. Facility to provide mechanical proof of accuracy.

Control of Bookeeping in Doctor's Office

Bookkeeping control is a commercial term that is sometimes used loosely. It refers to the exercise of accounting techniques that will always reveal errors. The subject is elaborate, and of necessity we must simplify it here. In a nutshell, its meaning to a doctor should refer to a system of bookkeeping procedures that would cause a smooth flow of figures and information into the records,

(Continued on page 208)

* Peat, Marwick, Mitchell & Co.

Notes and News

REHABILITATION INSTITUTE

The Governor's Institute on Rehabilitation, sponsored by the State Department of Health, and financed through grants from the U. S. Public Health Service, the Office of Vocational Rehabilitation, and the U. S. Children's Bureau, will be held January 10-24, 1960. Scheduled as a teaching institute for doctors, the teaching team will be headed by Dr. Leon Lewis of the Fairmont Respiratory and Rehabilitation Center, California, and will include an occupational therapist, a physical therapist and a vocational counselor from the Mainland. Other resource persons to complete the team will be chosen locally.

The tentative program and schedule for the Institute sessions follow:

PROPOSED PROGRAM
January 10-24, 1960

Monday, January 11
9:00 A.M. Visit Rehabilitation Center and Maluhia Hospital.
6:00 P.M. Dinner meeting at hotel, Honolulu.

Tuesday, January 12
7:00-9:30 A.M. Breakfast meeting for physicians, Princess Kaiulani Meeting House, Honolulu.
10:00 A.M.-12 noon Symposium for paramedical personnel, Princess Kaiulani Meeting House, Honolulu.

Wednesday, January 13
7:00-9:30 A.M. Breakfast meeting for physicians, Princess Kaiulani Meeting House, Honolulu.
10:00 A.M.-12 noon Symposium for paramedical personnel, Princess Kaiulani Meeting House, Honolulu.

Thursday, January 14
7:00-9:30 A.M. Breakfast meeting for physicians, Pali Palms Hotel, Kailua, Oahu.
10:00 A.M.-12 noon Symposium for paramedical personnel, Pali Palms Hotel, Kailua, Oahu.

Friday, January 15
7:00-9:30 A.M. Breakfast meeting for physicians, Kemoo Farm Restaurant, Wahiawa, Oahu.
10:00 A.M.-12 noon Symposium for paramedical personnel, Kemoo Farm Restaurant, Wahiawa, Oahu.

Sunday, January 17
7:00-9:30 A.M. Breakfast meeting for physicians, Hilo Hotel.
10:00 A.M.-12 noon Symposium for paramedical personnel, Hilo Hotel.

Monday, January 18
7:00-9:30 A.M. Breakfast meeting for physicians, Hilo Hotel.
10:00 A.M.-12 noon Symposium for paramedical personnel, Hilo Hotel.

Tuesday, January 19
6:00 P.M. Meeting for physicians, Wailuku, Maui.

Wednesday, January 20
9:00 A.M. Symposium for paramedical personnel, Wailuku, Maui.
6:00 P.M. Meeting for physicians, Wailuku, Maui.

Thursday, January 21
6:00 P.M. Meeting for physicians, Lihue, Kauai.

Friday, January 22
9:00 A.M. Symposium for paramedical personnel, Lihue, Kauai.
2:00 P.M. Meeting with Health and Welfare Council, Kauai.

J. WARREN WHITE, M.D.
1892-1958

Learn, as if you were going to live forever —live, as if you were going to die tomorrow.

This proverb expresses the way Dr. J. Warren White lived. He died the way I believe he wanted to, enjoying life at the summit of a remarkable career.

Dr. White was born in Boston on March 2, 1892, the son of Dr. Herbert Warren and Elizabeth Dudley White. He graduated from Roxbury Latin School in 1909, and attended Harvard, receiving the A.B. degree in 1913 and his M.D. degree in 1917. On August 18, 1917, he married Helen Angell, who remained his life-long companion.

He joined the Navy in 1917, serving at sea for 18 months. Then he was in charge of the orthopedic service at Chelsea Naval Hospital from 1921 until 1923. He then resigned from the Navy and entered private practice in Boston as an orthopedic surgeon.

In 1924 he came to Hawaii and became the first Chief Surgeon at the Shriners' Hospital for Crippled Children in Honolulu. This work with crippled children was to occupy the major part of the rest of his professional life. In 1927 he accepted the position of Chief Surgeon at the Shriners' Hospital in Greenville, South Carolina. He remained there until 1949, when the lure of the Islands impelled him to return, again as Chief Surgeon at the Honolulu unit.

All this time he had in addition been carrying on an active private practice in orthopedic surgery. In 1953 he joined the Straub Clinic in Honolulu as Chief of the Department of Orthopedics. When he reached the mandatory retirement age of 65 in 1957, he retired from the Shriners' Hospital, reluctantly, but continued in active practice.

On September 12, 1959, he was swimming on his rubber life raft off the beach at Waikiki, with his ever-present camera, taking pictures of the new apartment he had just moved into. This apartment had been planned with loving care and was to have been the retirement home for his wife, Helen, and himself. He had finished a roll of film when he experienced a fatal coronary occlusion. He is survived by his wife, Helen, and two sons, Warren, Jr., and Gilbert White.

Dr. White's energy was boundless; he couldn't contain it. He had a genius for friendship and his many friends were worldwide. His mechanical ingenuity and curiosity led to the development of new instruments and techniques in orthopedic surgery that have become standard today. Papers that he wrote and published encompass the entire field of orthopedics.

His gregariousness led him to membership in organizations and clubs too numerous to list. A few of them were the Aesculapian Club, Rotary, Adventurers, and Elks. He was a Scottish Rite Mason, Shriner, and Jester.

Professional organizations included the American Orthopedic Association, American Academy of Orthopaedic Surgery, American College of Surgeons, Western Orthopedic Association, International Society of Traumatic and Orthopedic Surgery, Pan-Pacific Surgical Association, American Medical Association, and Orthopedic Forum. He served on the Examining Board of the American Board of Orthopaedic Surgery.

Many honors were accorded him. Those of which he was most proud were his election to the Presidency of the American Orthopedic Association and the Presidency of the Western Orthopedic Association in 1955. In 1948 he was asked by the Surgeon General of the Army to conduct a teaching mission in Japan.

We have the memory of his dedication to his work, of his friendliness to all, and his unbridled enthusiasm and energy. Dr. White could never grow old. We will all miss him.

WILLIAM H. GULLEDGE, M.D.

wherever there is inflammation, swelling, pain

VARIDASE®

Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery. By activating fibrinolytic factors VARIDASE shortens the *undesirable phase,* limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection ...new simple buccal route

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.
Dosage: One tablet four times daily usually for five days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid.
Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.
Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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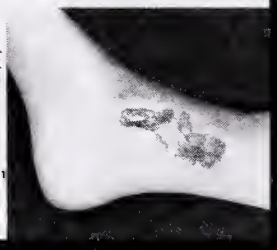




RCE INJURY

evere bruises
... swelling
... cleared
by fifth day[2]





VARICOSE ULCER

15 years duration
... resolved with
VARIDASE[1]

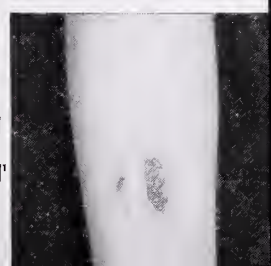




INFLAMMATORY DERMATOSIS

rapidly spreading
rhus dermatitis
healed within
a week[1]





INFECTED LACERATION

rked reversal
in 3 days...
returned
to school...
ure advanced[1]





THROMBOPHLEBITIS

back on his feet
in a week after
recurrent episode[1]





REFRACTORY CELLULITIS

normal routine
resumed after 4 days
of VARIDASE[1]

County Society Reports

Hawaii

The August meeting of the Hawaii County Medical Society was held at the Hilo Hotel on August 27, 1959. Twenty-four members were present, as well as seven guests—which included five nurses from the staff of the Hilo Memorial Hospital.

Dr. Benjamin Gazul, Chief of the Department of Pediatric Cardiology at Cook County Children's Hospital and a member of the Pediatrics Department, University of Illinois College of Medicine, gave a stimulating, informal talk on investigation of congenital heart disease, and illustrated his talk with slides.

After this presentation, a short business meeting was held. Only six members of the Society indicated an interest in securing the type of term insurance offered to the Honolulu County Medical Society.

Dr. M. H. Chang attended his first meeting after returning from two and a half months on the mainland. Like most residents of this peaceful island, he was not inured to the frenzied and endless stream of traffic which exemplifies life in most areas of the mainland. He was happy to resume the sedate traffic pace of Hilo.

Dr. Jacques Freeman, radiologist at Hilo Memorial Hospital, has resigned his position because he felt that after several decades of specialism it was unfair to require him to take a general medical examination to qualify for a license. He plans to go next to New York City.

* * *

The Hawaii County Medical Society met at the Naniloa Hotel on September 24, 1959. Members of the State and County Health Departments were guests at this meeting. Dr. Bockrath, new County Public Health Officer, was introduced to the Society. The featured speaker of the evening was Dr. Max Levine, Director of State Laboratories. Also present were Dr. Roy Nagakura, Veterinarian of the Board of Agriculture; Mr. Bert Gross of the Rodent Control Division; and Mr. Henry Minette of the Hilo Public Health Laboratory.

Dr. Levine spoke on the historical aspect of leptospirosis and then continued with a discussion of the laboratory diagnosis of the disease. He brought out many interesting inconsistencies between the in vitro and in vivo behavior of this organism. A short business meeting was held after Dr. Levine's speech.

HAROLD LEWIS, M.D.
Secretary

Honolulu

The Honolulu County Medical Society met on June 2, 1959, at 7:45 P.M. Dr. Richert presided and approximately 190 members and guests were present.

Mr. R. M. Kennedy, Executive Secretary, presented a talk on "Fee Schedules and How to Use Them." His talk included a discussion on the Society's Relative Value Fee Schedule, the new HMSA fee schedule, the Medicare fee schedule, and the present status of the Society's negotiations on the Workmen's Compensation fee schedule.

Dr. Milton Trager was welcomed into the Society as a new member.

Dr. Batten informed the membership that Governor Quinn has signed Senate Bill 1162 which appropriates $200,000.00 in matching funds for the construction of a new Medical Library. He stated that such funds will come from the issuance of bonds and that the bonds will be issued with respect to priority. He stated that the high priority of the Library's appropriation depended upon the doctors, and suggested that they write letters to the Priority Committee stressing the present conditions as they exist today and the immediate need for expansion and improvement. He further stated that the $200,000.00 plus what the Library already has which amounts to $116,000.00 will not solve the problems of building, and he urged the doctors to keep making their individual contributions. He mentioned that some concern has been expressed relative to the increase of dues, but he reassured the doctors that there was no intention of increasing the dues as there is an endowment fund which the Library will use for the first time to help defray the cost of operations of the Library.

Dr. Richert opened the meeting by stating that tonight's business would be to reevaluate the action taken by the membership at the April 7 meeting on Section 15 of the HMSA Administrative Instruction and Procedure manual. It was felt by HMSA and many members of the Society that what they had voted on that night was not clear in everyone's mind and it needed further clarification and review. He explained briefly that before Section 15 was amended it permitted the payment of services to two physicians by HMSA, but the action taken by the membership at the April meeting removed the privilege of the referring physician to submit a separate claim for his services.

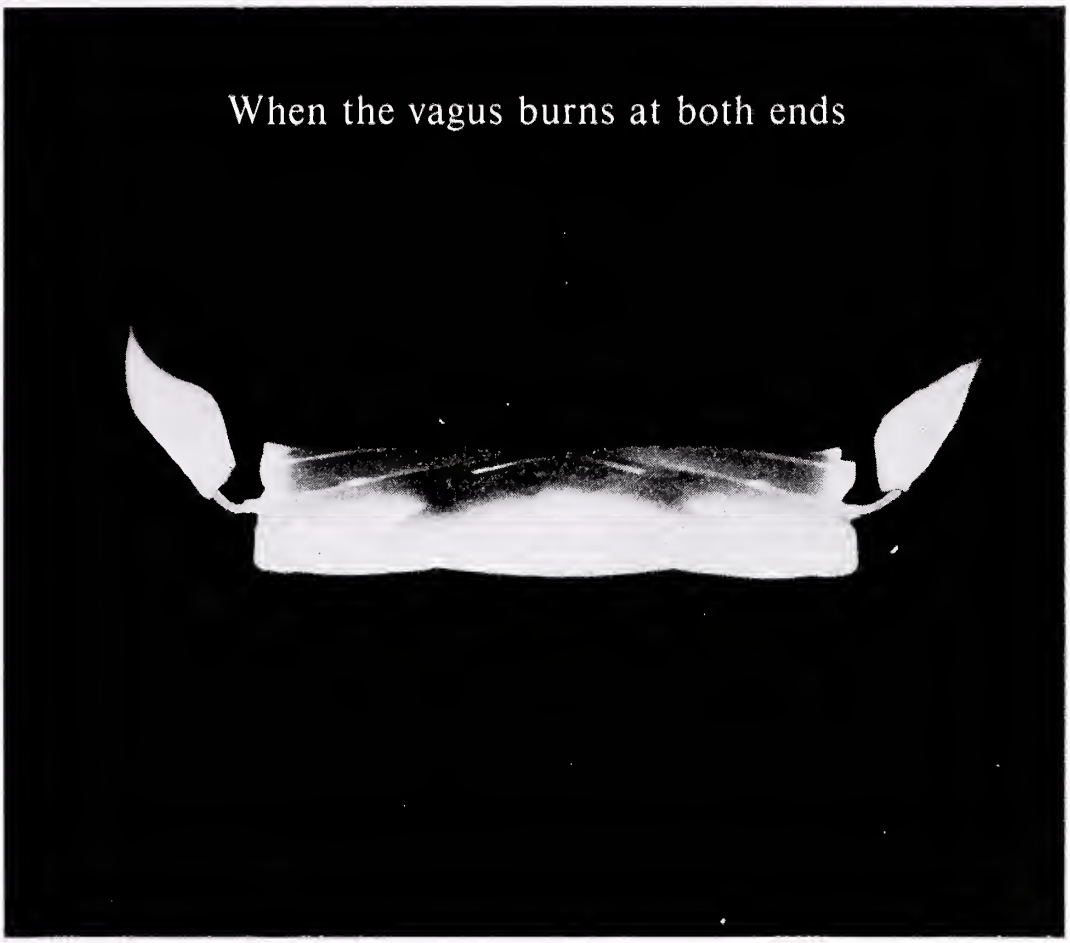
Dr. Allison reviewed from the beginning the Division of Surgical Fees Committee which was appointed by Dr. West primarily for the purpose of discussing the problem of itinerant surgery and the fees relating to HMSA. He stated that this *ad hoc* committee made up of surgeons and general practitioners, after deliberating for more than a year, finally came up with a report which has been approved by the Board of Governors, circulated to the membership, and is now being presented for consideration and approval. Following a quick review of each section of the Committee's report, Dr. Allison moved that this report be accepted. The motion was seconded by Dr. West.

Following Dr. Allison's motion, a question was asked as to whether the Chair intended to rescind the motion of the April meeting. Dr. Richert stated that it was the intent of tonight's meeting not to rescind the action, but to bring this matter back to the membership for reconsideration and a full discussion of the entire subject. However, if after adequate discussion, and if someone has a recommendation to make which is concrete and agreeable to this entire body, he would entertain a motion to amend the action of the April meeting.

Dr. Millard, who opposed the action taken on paragraph 15, stated that inasmuch as he felt that the membership did not understand what they had voted on at the April 7 meeting, he would like to move that the action taken on paragraph 15 pertaining to the payment of two physicians be rescinded. The motion was seconded by Dr. Edmund Lee.

Dr. Richert stated that inasmuch as he would like to see a full discussion held on this matter and every member given the opportunity to express his opinion, he

(Continued on page 206)



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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

ROSIE CHANG, *Editor*

FLORA OZAKI, *Associate Editor*
KATSUKO ENOKI, *Associate Editor*
HAZEL KIM, *Associate Editor*
MILDRED KIM, *Associate Editor*

OLIVE C. PRIDGEN, *Executive Secretary*

President's Message

President's Message

With a New Year opening before us, one *good* resolution that will be *kept* is better than several half-hearted attempts that never reach fruition. So, as a follow-up to our Convention, think what would happen if every member of Hawaii Nurses' Association resolved to recruit one new member for 1960! With registered professional nurses *licensed* in Hawaii hitting well over the two thousand mark, our goal would reach a total membership of at least fifteen hundred if each of us now paying dues would really work on this *one* New Year's resolution.



SISTER MAUREEN
President

We have heard of the S-triangle—service, spirit, and skill—as a foundation for good nursing care. Could we consider another S-triangle as a motivating force in boosting our membership?

Spine – Spirit – Sparkle! Have backbone enough to work actively on this *one* new member you will interest in your professional organization. Be animated with a spirit of pride in your association that will be contagious and spread to others. Let those stars in your eyes sparkle again with that generosity of spirit that will deepen and strengthen your own conviction that—

nursing is a noble profession

God's blessings in abundance be yours this glorious New Year!

Editorials

The Christmas and New Year holidays will soon be here. These holidays are the most festive of the year. The degree in which one enjoys them depends upon the individual. Similarly, the benefits that you derive from the Nurses' Association depends upon the degree of your participation and support.

Let everyone resolve to take a more active part in the Nurses' Association. Let us help increase our membership and aid in the development of an effective economic security program in 1960.

The editor and the staff of the INTER ISLAND NURSES' BULLETIN extend best wishes for a Happy New Year to you and your family.

IMPORTANT NOTICE!

This is to advise you of our change of name and address from:

Territory of Hawaii
Board for the Licensing of Nurses
510 South Beretania Street
Honolulu 13, Hawaii

to

State of Hawaii
Board of Nursing
Third Floor, State Office Building
Honolulu 13, Hawaii
Telephone Number: 54328

Effective Monday, September 28, 1959



CHARTER MEMBERS HONORED recently by the Maui Nurses' Association were (left to right): Mrs. Modesta Singlehurst, Mrs. Margaret Kinney, Mrs. Molly Martin, Mrs. Lillian Gill, and Mrs. Alma Anton.

Maui Nurses on Parade

Maui's Silver Anniversary

The coming of the year 1960 will commemorate the Maui District Nurses Association's Silver Anniversary. In March of 1935 a small group of nurses got together and organized the nucleus of the Maui District Nurses Association. By the end of that year there were about 46 active members in the association, many of whom are still in active nursing today.

KEY TO MAUI is presented to Sister Maureen, guest speaker at the Maui District Nurses' Association installation dinner on June 26, by County Chairman, Eddie Tam.



MAUI NURSES CONTINUED



MAUI NURSES seated (left to right) are the newly elected and holdover officers for 1959-60. They are: Masami Shiraki, Corresponding Secretary; Alma Anton, Treasurer; Lorraine Masumoto, Recording Secretary; Yukiko Higa, Vice President; and Marjorie Okinaka, President. Members standing in the back are the outgoing officers, Board of Directors, and committee members, and include H. Eileen MacHenry, Elizabeth S. McCall, Anne Gillin, Lillian Gill, Margaret Alexander, Virginia Scheeline, Grace Lusby, Modesta Singlehurst, Theresa Muller, Hilda Yatsushiro, Molly Martin, Alice Arakawa, Gloria Foster, Clairborne Vaughn, Hilda Akana, and June Ikemori.

Maui will be the site for the annual Territorial Nurses convention in 1960 and the Maui nurses will act as hostesses. A bazaar was held on April 18, 1959, at the Kahului Union Church Hall for the purpose of making enough money to cover expenses for 1960. Plans are already being made for this special occasion.

Dr. Chung-Hoon Speaks to Maui Nurses

The Maui Nurses had the honor of having Dr. Edwin Chung-Hoon, Chief of Medical Service, Division of Hansen's Disease from the Department of Health, speak on Hansen's Disease. With the aid of excellent colored slides, he presented the different skin diseases resembling leprosy and explained how a differential diagnosis can be made in each case. Beautiful scenic slides of Hale Mohalu and the Kalaupapa Settlement were shown. A very interesting and informative evening was spent by all.

Installation Dinner

The annual installation dinner of the Maui District Nurses Association was held on June 26 at the Central Maui Memorial Hospital nurses' cottage lounge with approximately 43 members present. This event, chairmaned by Mrs. Elizabeth McCall, was enjoyed by all.

Sister Maureen, President of the NATH, was welcomed to Maui by county chairman, Mr. Eddie Tam, who presented her with the key to Maui. Sister Maureen as guest speaker gave an interesting, vivid account of her trip to the ANA conference held in New York for the Advisory Council.

The highlight of the evening was the presentation and installation of the newly elected officers Mrs. Yukiko Higa, Vice President, and Mrs. Lorraine Masumoto, Recording Secretary, by Mrs. Marjorie Okinaka, President. Elected to the Board of Directors were Mrs. McCall, Mrs. Lorraine Arakaki, Mrs. Lillian Gill, and Miss Helen Goshi.

Honored at the dinner were five charter members of the Maui Nurses Association, Mrs. Ann Gillin, Mrs. Molly Martin, Mrs. Margaret Kinney, Mrs. Lillian Gill, and Mrs. Alma Anton.

Hawaiian entertainment was provided by the Kula Sanatorium musicians.

Future Nurses Entertained

Seventeen future nurses enjoyed a night of fellowship and orientation to nursing on Thursday, July 23, at the Keawe Kapu home of Miss Eileen McHenry.

A potluck supper, entertainment, and group sessions were the program for the evening.

This event, which is held annually by the members of Maui Nurses Association, is open to all recent high school graduates who are looking forward to a future in nursing.

Maui Nurses Win Degrees

Miss Setsuyo Ushiro and Miss Elizabeth Morishige, both former graduates of The Queen's Hospital School of Nursing in Honolulu, received their Bachelor of Science Degree in Nursing in August of this year from the University of Hawaii. They are both employed by the Health Department on Maui.



Book Reviews

Trends in Nursing History, 5th Ed.

By Elizabeth M. Jamieson, Mary F. Sewall and Lucille S. Gjertson, 522 pp., $5.00, W. B. Saunders Co., 1959.

The changes in this new edition were made mainly to integrate Professional Adjustments II with Nursing History. The authors attempted to accomplish this by shortening all chapters except those on recent and current events and by adding subject matter of Professional Adjustments II of historical nature. With such changes the result is a more readable and better written book.

Readability has been markedly improved by better chronological organization and elimination of much detail found in previous editions, shortening chapters without detracting from the total context. Chapter 14, "Modern Trends in Nursing," has been revised, describing the structure, functions, and responsibilities of nursing organizations and giving a more detailed account of recent research programs. Subject matter in Chapter 15, "International Relationships," includes the activities of the International Council of Nurses, the International Student Nurses' Unit, and developments in nursing in other countries. Chapter 16, "Modern Nursing Careers," is a new chapter which briefly reviews some of the career opportunities, legal responsibilities, economic security, and sources of scholarships for advanced education for nurses.

As a reference or text in a Nursing History course, this book will be interesting and helpful to instructor and student. The historical development of nursing is presented in relation to the history of mankind, the social, economic, cultural, and scientific forces which have influenced nursing throughout. Emphasis on the role of nursing in the total health of the world serves to broaden the reader's perspective of the profession.

For a course in Professional Adjustments II, there are other texts which cover specific subject areas more comprehensively and are more useful. Coverage given in this book is so brief, further reference reading is a real necessity.

B. Mitsunaga, R.N.

Orthopedic Nursing, 3rd Ed.

By Mary Powell, S.R.N., M.C.S.P., pp. 464, $6.50, The Williams & Wilkins Co., 1959.

This is a good reference book for instructors as well as student nurses in orthopedic nursing. It is written in a well-organized, easily understood style. It covers techniques, equipment, and nursing measures utilized in the care of the orthopedic patient. Orthopedic conditions are covered adequately and emphasis is placed upon nursing care involved.

Although skeletal tuberculosis is relatively uncommon today, a good portion of the text involves care of the tuberculosis patient, illustrating the basic principles of immobilization which are applicable to the care of any orthopedic patient. It has many simple illustrations that help to clarify the principles involved.

Ruth Uyechi, R.N.

Communicable Diseases, 8th Ed.

By Albert G. Bower, M.D., Edith B. Pilant, R.N., and Nina B. Craft, R.N., 704 pp., $7.50, W. B. Saunders Co., 1958.

This is the eighth edition of a communicable disease text which the reader will find to be well organized, compact, and informative The first few chapters, dealing with the definitions of terms, description of medical aseptic technique, home care of the patient, and the public health control of communicable disease, will provide valuable background before perusal of the text.

The authors have conveniently rearranged the chapters and covered each disease in a concise and descriptive manner, including definition, etiology, pathology, incubation period, symptoms, diagnosis, treatment, and the nursing care. The section on nursing care gives very adequate information on general management and care, including the psychological aspects, and follow-up in the home and community.

The illustrations, study questions, reference reading lists, and glossary of medical terms will be valuable adjuncts to the instructor and student utilizing this text.

Irene Kawamura, R.N.

Nursing Education and Nursing Service

Hawaii Student Nurses' Association

There has been a definite movement toward the trend for the professional nurses' organizations to work with the professional student nurses' associations. Because of this new development it is the purpose of this article to introduce the Hawaii Student Nurses' Association to you and to inform you of its activities and accomplishments.

The Hawaii Student Nurses' Association, commonly known as HSNA, now a State Association, is affiliated with the National Student Nurses' Association. HSNA had its beginning when the professional student nurses found a need to meet to discuss plans for their professional growth. It was at this time that the purposes of the organization were established. These are:

1. To aid in the development of student nurses as truly democratic citizens by broadening their horizons as individuals and as members of a group.
2. To promote professional and social unity among the student nurses of the Hawaii Student Nurses' Association.
3. To stimulate an understanding of and an interest in the programs of the graduate professional nursing organizations.
4. To serve as a channel of communication between the student nurses' organizations and various units of graduate professional nurses' organizations.
5. To participate as an active constituent of the National Student Nurses' Association through duly elected representatives.

At present the officers of this organization are:

President: Emmalina Endo, Senior, Univ. of Hawaii
First Vice-President: Gladys Yamanaga, Senior, Queen's Hospital
Second Vice-President: Marjorie Oda, Senior, St. Francis Hospital
Corresponding Secretary: Lorraine Yamane, Junior, Univ. of Hawaii
Recording Secretary: Evelyn Chinen, Soph., Univ. of Hawaii
Treasurer: Agnes Uchida, Senior, Queen's Hospital

The advisory board is composed of: Mrs. Elsie Smith, Mrs. Betty Mitsunaga, Miss Mildred Abe, Miss Jean Uyeda, and Mrs. Scully, lay advisor.

This year, for the first time, HSNA has been able to establish a scholarship fund to aid an undergraduate student in each of the schools of nursing. The money for the scholarship comes solely from a Benefit Scholarship Dance held annually. This past year it was held in February, 1959, at the Longhouse in the Kaiser Hawaiian Village. It was deemed a success.

Another new experiment was tried by this year's council which apparently proved to be successful. HSNA held an association meeting every other month at which time the entire membership was invited. The attendance at these meetings was between 60 and 100 people. The meetings included: a panel of foreign students who shared their impression of Hawaii, and discussed "Nursing and Nursing Education of their Countries," as well as a panel discussion on the fields of nursing, which included nursing in the armed forces, nursing in mental health, nursing in World Health Organization, and industrial nursing. In April HSNA held its annual picnic at Ala Moana.

While all of this has been happening, the Council has been working hard to acquire status with the Nurses' Association, Territory of Hawaii.

The first indication that this goal might be achieved was as early as one of the first meetings of the present Council. This was the participation of the student nurses in the Nurses' Association Convention held in October, 1958. Here the students found out about their organization and many problems were clarified. With the aid of Mrs. Olive Pridgen, Executive Secretary of NATH, and Mrs. Margaret Carroll, Executive Secretary, American Nurses' Association, students began to see their place in such an organization.

Although the growth of HSNA has been slow and tedious, it has been steady enough so that many of the goals which once looked hard to attain, are now within reach. HSNA is growing and experiencing many problems. We hope that the trend of associating with the professional nurses' association will come to pass because it seems only natural that much help from NATH should be obtained to help its future members attain their professional growth while they are still students.

Report on Nursing Services Conferences Held at Red Cross Training Center

A ten-day conference of the total Nursing Services staff of the American National Red Cross was held at the American Red Cross Training Center in Charlottesville, Virginia, from July 27 to August 5, 1959. One hundred and thirty nurses from

all over the United States, Puerto Rico, and Hawaii attended. These nurses represented the full paid staff of Nursing Services. Several volunteer nurses also attended.

The conference was the first ever held for the nursing program which celebrated its 50th Anniversary in May.

The keynote of the conference was improvement of nursing services for older citizens. Two new programs were introduced for discussion and both were aimed at bettering the profession in these lines. One is called "Fitness After Forty" and involves teaching a course on maintenance of health for older persons. It aims to develop attitudes, outlooks and habits in older people that will help them maintain the best possible health status.

All of the conferees were given a one-day Instructor Training Course and authorized to teach this new addition to the Nursing Services program. The first class in "Fitness After Forty" here in Hawaii will be presented in the near future.

The second was the explanation of a program which is being conducted in cooperation with the United States Public Health Service. The Red Cross will assist in training nursing aides employed in nursing homes to improve the care given to patients in these homes. Some communities on the Mainland have these programs in operation now.

The American Red Cross nurses also reviewed other programs which are sponsored through their services.

A number of consultants were on hand to discuss programs and to conduct panel discussions. Mr. Malcolm Knowles, a consultant in adult education for American Red Cross from Wilmette, Illinois, and Mr. Leslie This, Assistant National Training Director for Red Cross Headquarters in Washington, were present throughout the conference.

A panel of experts on the problems of the aged were present. Dr. Henry Page, a member of the medical service staff of Lankenau Hospital in Philadelphia; Miss Ollie Randall from New York City, a member of the National Committee on the Aging; Mrs. Kathleen Shafer, an author of a book on geriatric nursing; and Dr. John A. Lewis, psychiatric consultant with the United States Public Health Service, led a very interesting discussion on problems of the aging. Other consultants assisting the panel were: Miss Ruth Adams, Deputy Director of Nursing Services for the Veterans Administration in Washington; Mrs. Frances Walford, Consultant with Public Health Service in Washington; and Miss Catherine Sullivan, Chief Nurse with the Offices of Civil and Defense Mobilization.

Also attending and assisting at the conference were American Red Cross officers from National Headquarters in Washington, D. C., Mr. George Elsey, Vice President; Mr. Robert Edson, Director of Disaster Services; Dr. Sam Gibson, Senior Medical Officer; and Miss Phoebe Steffey, Assistant Director of the Office of Volunteers. Pertinent information regarding their respective services were presented by the officers.

It was a privilege to be able to attend this conference, the first all-staff nursing conference ever held. All of the conferees felt that it would be a landmark, especially since it was held during the year in which Red Cross Nursing Services celebrates its fiftieth anniversary.

After learning the content of the new course, "Fitness After Forty," I find myself feeling that I might be able to agree with the famous lines from Robert Browning's poem, Rabbi Ben Ezra, "Grow old along with me! The best is yet to be . . ."

LOUISE CRUTE
Director
Nursing Services

Report on Mental Health Conferences Held at University of Colorado

In July, 1959, Miss Eleanor Cranch, instructor at the College of Nursing, University of Hawaii, attended a five-day conference on mental health at the University of Colorado Medical Center in Denver. The conference was sponsored by the University of Colorado School of Nursing in cooperation with the Mental Health Section, U. S. Public Health Service, and the National Institute of Mental Health.

The twenty-four psychiatric and public health nurses attending the conference represented various aspects of nursing care. There were staff nurses, instructors, head nurses, supervisors, and directors enrolled. Resource people included a coordinator of psychiatric nursing, two mental health nursing consultants, an instructor in psychiatric nursing, graduate nurse students in psychiatric and public health nursing, a resident physician in psychiatry, and a director of occupational therapy in a mental hospital.

The theme of the conference was mental health in the hospital and in the home. Highlighting the conference was skillful role-playing by resource people and graduate students representing a logical progression of care for the same patient—the morning report and the patient, the patient and the nurse, a psychiatric team conference about the patient, the nurse and the supervisor discuss the pa-

tient, the nurse and the patient again, the nurse and the public health nurse discuss the patient, the supervisor, mental health consultant, and the public health nurse discuss the patient. Following the role-playing, there were large group discussions with resource people and small group discussions with designated group leaders.

To facilitate participation, all members attending the conference were given mimeographed copies of the process recordings for the nurse-patient relationships and staff interactions in each sequence of the role-playing.

One conclusion reached by the members of the conference was that home care of the former mental patient does not differ radically from the care offered by public health nurses to other patients. Miss Cranch stated that the over-all aim of home care for the discharged psychiatric patient is the same as for all patients; namely, to help the patient develop his highest potential for healthy living and satisfying relationships in the family and in the community.

Additional activities during the conference provided opportunities to view the film *Nurse-Patient Relationships in Psychiatry,* to hear two reports of unpublished masters' theses, and to observe a psychiatric team conference. To balance the intensive educational program, there were two social events: a dinner followed by an old fashioned western melodrama, and a very special chicken barbecue picnic in the mountains which was sponsored by the graduate students.

ELEANOR CRANCH AND
FLORA OZAKI

General Interest

Nursing in the 50th State

Today, the eyes of the nation are focused on Hawaii. Everyone wonders what it is like. For those in the nursing field, interest naturally is focused on the kind of care available in Hawaii.

HAWAII'S DESCRIPTION

With well qualified and trained nurses, the people of Hawaii receive as good nursing care as found anywhere in the United States.

How does one describe Hawaii to the nursing world? Hawaii is 16,435 square miles, or greater in area than either Delaware, Connecticut, or Rhode Island. A group of eight islands makes up the State of Hawaii. There is a diversity of racial and cultural backgrounds of people here—Americans of Japanese, Chinese, Korean, Hawaiian, Filipino, Caucasian, and other racial descents live and work and play side by side.

Of the 600,000 people, over 450,000 are on the Island of Oahu where Honolulu, the capital of Hawaii, is located. The number of nurses on Oahu exceeds that of all the other islands put together.

The Mabel L. Smyth Memorial building in Honolulu is the headquarters of the medical and nursing associations. The building is a memorial to the first of Hawaii's daughters who played a major role in island nursing history—Miss Mabel L. Smyth, a part-Hawaiian Public Health nurse. To her is due much credit for the lowering of maternal and infant mortality through her sympathetic and warm-hearted contacts with people of all races. After her death more than twenty years ago, money was collected for erecting the building in her memory. The building is said to be the only one of its kind in the world that was erected jointly by nurses and doctors and it represents the spirit of cooperation so abundant in Hawaii.

By law, Hawaii recognizes two types of nurses —the registered and the practical, both of which must meet high standards. During the year ending June, 1958, there were 2,131 professional nurses and 1,687 practical nurses at work.

OPPORTUNITIES

What are the opportunities for mainland nurses to gain employment in Hawaii? Persons seeking employment in Hawaii are always urged to come with sufficient money to tide them over a period of unemployment. It is wise to write in advance to one of the hospitals, the Department of Health, or the Hawaii Board for the Licensing of Nurses.

There are 31 hospitals in Hawaii including general hospitals, plantation hospitals, a mental hospital, four tuberculosis hospitals, a Hansen's Disease hospital, the Shriner's Hospital for Crippled Children, and the Tripler Army Hospital, one of the largest Army hospitals under the American flag.

Vacancies are frequently occurring but the supply of professional nurses is such that there are not so many opportunities here as there are in other parts of the United States. There would probably not be a delay for a qualified nurse to obtain a position in one of the more remote areas in Hawaii. While working conditions are modern in the rural areas, social and recreational opportunities are limited, as they usually are in any small town.

More and more graduates of local schools are seeking advanced education in their area of interests in mainland colleges. As a result the hospitals

and schools of nursing are able to fill some of their top level positions with qualified local nurses. Hawaiian nurses are nursing in hospitals and agencies all over the world.

Nursing Education

What are the opportunities for Hawaii's young women to receive nursing education locally? There are two hospital schools of nursing and a university school of nursing. All are fully accredited by the Accrediting Service of the National League for Nursing and are located in Honolulu. Total enrollment runs between 400 and 450. In competition in NLN examinations, Hawaii's nurses rank in the upper 10 per cent of the nation. There is also a Practical Nursing School and this too is located in Honolulu.

The Queen's Hospital School of Nursing was established in 1916, and was the first in Hawaii. Over 900 young women have been graduated. They hold positions in Hawaii and throughout the world. Since 1956, The Queen's Hospital has opened her doors to men students and the first male student graduated in August.

The Queen's Hospital is the only hospital in the United States to be founded by Royal Charter and through the personal efforts and contributions of Royal personages. With her husband, King Kamehameha IV, Queen Emma was instrumental in the founding of The Queen's Hospital in 1860. The school song, *Ka-lele-o-na-lani,* was originally a greeting sung to Queen Emma on one of her visits to the Island of Kauai. Queen Liliuokalani, the last ruler of the Royal Hawaiian Kingdom, designed the school's pin. Her personal motto, *Onipaa,* meaning steadfast, is the school's motto and it is engraved in gold against the purple background of the school pin.

St. Francis Hospital School of Nursing is the second largest in Hawaii. At the request of King Kalakaua, seven Franciscan nuns from Syracuse, New York, came to Hawaii to give nursing care to the patients in the leprosy colony on the Island of Molokai.

Since their arrival in 1873, the Franciscan Sisters have made many contributions to the history of Catholicism in Hawaii. Among their accomplishments is the establishment of the St. Francis Hospital in 1927 and the School of Nursing two years later. Today the St. Francis Hospital School of Nursing provides a center of Catholic nursing education in Hawaii. The philosophy underlying the curriculum is in conformity with the high ideals of Catholicism. Students of all religions, as well as all races and nationalities, are eligible for admission.

The University of Hawaii College of Nursing is located in beautiful Manoa Valley, three miles from downtown Honolulu and two miles from Waikiki Beach. Its land holdings total some 710 acres.

The University of Hawaii, the only state supported university in Hawaii, first displayed its interest in nursing education in 1931 when it established a program of study in Public Health Nursing, which was approved the next year by the National Organization for Public Health Nursing. This program, with its various curriculum revisions, has remained a part of the degree program for graduate nurses ever since. It has helped to make possible the record Hawaii has held for some time; i.e., the highest percentage in the nation of its employed Public Health nurses having completed a program of study in public health nursing. In 1952, by legislative mandate, the University established a School of Nursing to provide a four-year program leading to a Bachelor of Science degree to prepare professional nurses. This program, too, includes preparation for Public Health Nursing.

Recently the school achieved the status of a college, one of eight in the University. Its student body numbering around 160 is made up of students of many racial backgrounds and from various mainland states, Hawaii, and foreign countries, mainly Formosa, Korea, and the Philippines. Because the University of Hawaii has no university hospital, students in nursing use many different community agencies for instruction. Students are able to live at home and, throughout their four years, spend part of each week on the University campus attending classes with other students in all fields of study and participating fully in campus activities. The 127 graduates of the University nursing program are practicing in many mainland states as well as in Hawaii.

The Practical Nursing School is fully accredited by the Hawaii Board for the Licensing of Nurses. A group of island educators recognized the need for training practical nurses and planned with the Department of Public Instruction for the establishment of a Practical Nursing School. The first class of 22 students enrolled in the course in October, 1947.

Since its inception 11 years ago, over 600 students have completed the 12-month course. Students of all races come from the neighboring islands and range in age from 18 to 50. Six hospitals provide clinical experience, including the Territorial Hospital for psychiatric nursing.

Upon completion of the program, graduates are eligible to take the NLN examination for license as practical nurses. The need for well-trained practical nurses, both men and women, continues to

increase in hospitals, doctors' offices, homes, and public health agencies.

Public Health Nursing

Public Health Nursing in Hawaii is provided by the Territorial Department of Health with funds received through legislative action. There are no voluntary public health nursing agencies nor are there any visiting nurse associations.

The public health nurses carry on a generalized program which includes services in maternal and child health, school nursing, crippled children, chronic diseases, communicable diseases, and rehabilitation.

Public Health Nursing in Hawaii had its beginnings in 1897, when, on a volunteer basis, a registered nurse gave services to the kindergartens and into the homes of "little children who came to school dirty, hungry, and covered with sores." Hawaii now has 79 staff Public Health nursing positions, plus additional positions for supervisors, consultants and administrators.

Hawaii has a 100 per cent fully qualified staff in the Bureau of Public Health Nursing. All members meet the minimum requirement of having completed a course in Public Health Nursing on the university level accredited by the National League for Nursing.

Health Statistics

In all fields of medicine and nursing, Hawaii has ranked high and evidences of this are found in its vital statistics. The lowest crude death rate among civilians in Hawaii's history of 5.3 deaths per 1,000 population was recorded for 1958. Comparable death rate for the United States was 9.5 per 1,000 population.

Striking progress has been made in saving the lives of infants under one year of age and reducing maternal mortality. The infant death rate in 1940 was 43.7 per 1,000 live births compared to 23.0 per 1,000 in 1958. For the United States, the infant death rate in 1958 was 26.9 per 1,000 live births. The maternal mortality rate for Hawaii dropped from 24 deaths per 10,000 in 1940 to 3.0 per 10,000 live births in 1958. For the United States the maternal mortality rate was 2.9 per 10,000 live births in 1957.

In 1957 the death rate from tuberculosis in Hawaii reached the low figure of 3.1 per 100,000 population in contrast to 7.5 per 100,000 for the nation as a whole.

These gains in the health field in Hawaii have been in no small measure due to the high level of the nursing profession here!

Rosie K. Chang, R.N.

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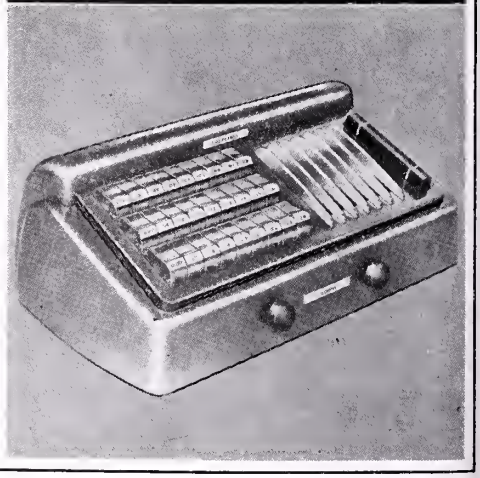
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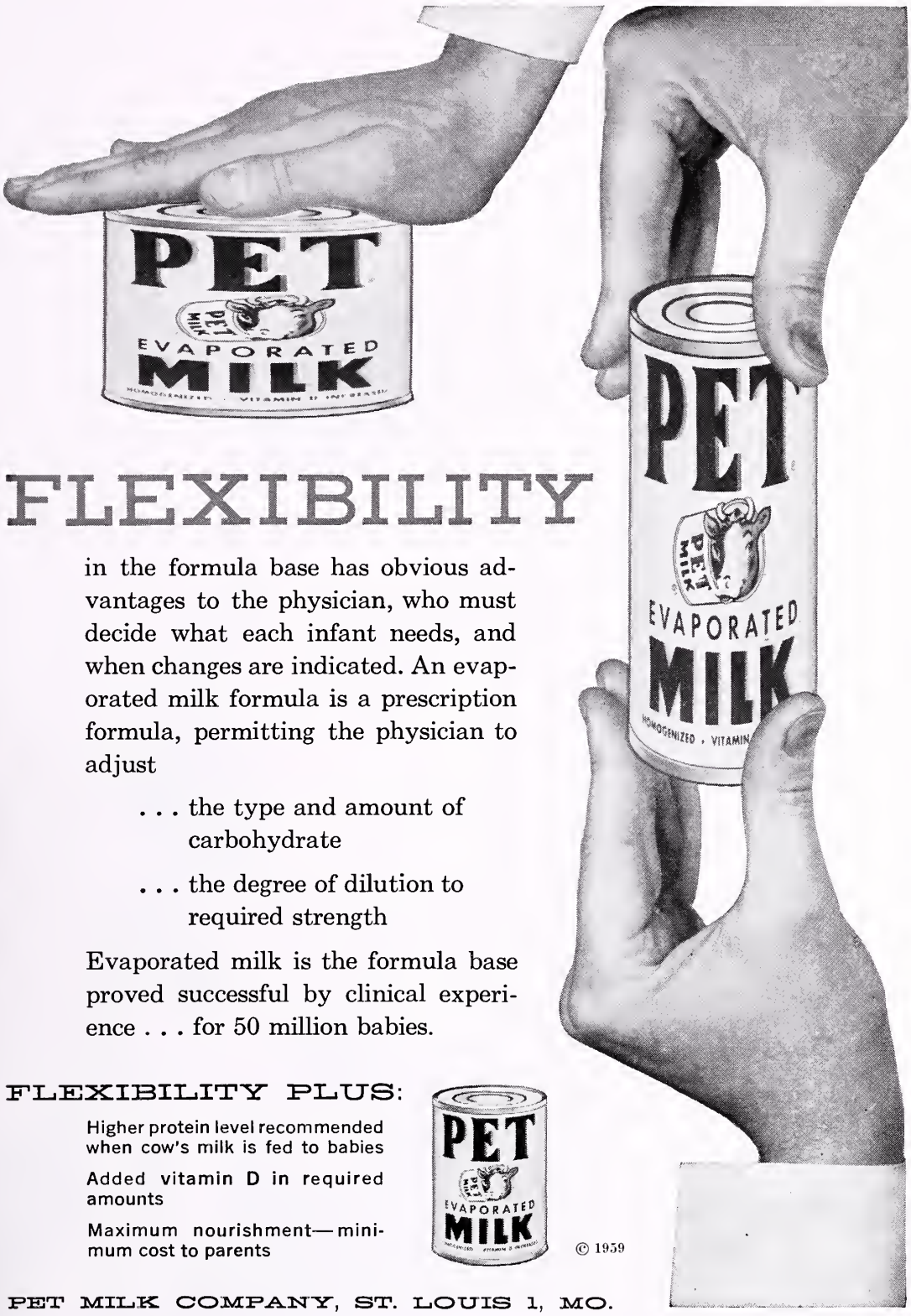
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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

LYDIA C. MARTENS, *Editor* ETHEL NISHIBATA, *Associate Editor*

The Future of Medical Technology in Hawaii

What can young people look forward to if they choose to enter the profession of medical technology in the 50th State?

One thing of great importance is that they can live at home and attend an excellent school for medical technology right here at the University of Hawaii. The affiliated hospitals, Queen's, St. Francis, Kuakini, and Tripler, offer broad and intensive internship experience and, lastly, the field for positions is wide open. There has never been so great a shortage of Med Techs, both locally and nationally, as there is at present.

The profession is young but scarcely any other has grown as rapidly in scope and responsibility. Medical technology in Hawaii demands a devotion to duty and dedication to the profession that goes far beyond eight hours of work and loyalty to the employing institution.

No medical technologist that I have known, who was worthy of the appellation, ever hesitated to spend long hours overtime for emergency work or to cover when the need arose. We could inject here that the medical term "emergency" is interpreted in a number of remarkable ways—aside from Webster's definition!

I have tried to piece together the reasons for the current shortage of Med Techs. There are several:

1. The number of students with an initial interest in the field is limited.

2. The course requires the study of chemistry, bacteriology, and other science subjects rather difficult for the majority, and technical skills must be acquired, which are quite foreign to ordinary, everyday living.

3. Salaries paid locally are too low. Ours is a materialistic age. The salary range of a profession and the environment in which it places people more often than not determines a choice.

I ask, "What incentive to be a medical technologist is offered in Hawaii?" There can be the satisfaction of providing service to the sick, the opportunity to work with well educated scientists and doctors, a worthwhile way to earn a livelihood in a growing field. The huge research project in the offing at the University of Hawaii promises great opportunity. Roughly, after five years of schooling beyond high school, the salary range for an ASCP (National) registered med tech in a hospital runs from $320.00 to $380.00 a month with fringe benefits of group insurance, Social Security, and low cost meals. This is just a little below a junior accountant (bookkeeper). I have been unable to obtain a pay scale for chief or head medical technologists. It is probably $20.00 more than the regular registered med tech just out of school. This does not compare favorably with West Coast or Middle West salaries. The salaries on the East Coast are similar to ours but it is my observation, reading the "help wanted" ads in the latest journals, that they too labor under a shortage of trained help.

I frown on methods of coercion and believe that anyone in the medical profession who goes on strike is away off in left field. By the same token, management that "kills the goose that lays the golden egg" for them, is just as far off. In theory, longevity is lauded, in practice, I have observed that the "old work horse" may drop in their tracks under a load, or, if they don't like that, may quit. This, on the face of it, may seem to be good business—a new employee starts at the bottom of the pay scale. The catch of it is, that two are usually needed to fill the vacancy.

But I have hopes that the truth will eventually win out. A hospital without a laboratory is quite unthinkable, and the situation appears to be improving. In Michigan, technologists and pathologists got together and recommended a starting salary of $4,800.00 a year, the same as for school teachers. This has been done in other areas too. Would it not be in order for the local chapter of the ASMT with the help of the Hawaii Society of Pathologists to initiate a joint study of the situation and come up with a recommendation?

Civil Service has at last recognized the profession and the pay starts at $405.00, with retirement benefits.

Few people have complete social security such as a devoted Christian in a religious order may have. Money is not everything for the employee but it works both ways—neither should it be for the employer. A meeting of the minds could make medical technology the chosen profession of many.

LYDIA MARTENS

Aloha to Miss Martens

On or about the fifteenth of December the State of Hawaii, the Hawaii Society of Medical Technologists and Kauikeolani Children's Hospital lose to retirement and the Mainland, one of our foremost unsung heroines. We refer to Lydia Carolyn Martens; Editor of this BULLETIN, Chief Technologist at Children's, charter member and Past President of HSMT, and inspiration to many, both in our profession and out.

Born in Grant Park, Illinois, she started her training in 1924 in St. Paul at Beebe Laboratories, one of the first schools for medical laboratory technicians. The school was directed by Dr. Walter E. King, a Merck Company research man, who at that time was trying to impress M.D.s with the value of "blood pictures" in diagnosis.

After working for some time at St. Joseph's Mercy Hospital under Dr. Carl C. Warden, she was employed at the Department of Preventive Medicine of the A. O. Smith Corporation, Milwaukee and then swore never to work for an M.D. again.

On October 2, 1930, dim days for more than a few, Miss Martens arrived in Hawaii in answer to Children's Hospital's need for a head (and only) laboratory and x-ray technician. For the next nine years she covered both jobs twenty-four hours a day, seven days a week, acquiring help only after her round-the-world tour in 1939.

The list of men whom she has worked at Children's reads like "Who's Who." In the x-ray department there were Dr. G. Schnack, Dr. Smith, and Dr. Phillip Arthur. In 1950 the two departments were separated and Miss Martens devoted herself exclusively to the laboratory. In the laboratory has been Dr. Yang, now Korean ambassador to the United States; Dr. Eric Fennel, a pioneer and true friend of medical technology who was instrumental in the drawing together technologists and pathologists; Dr. Thomas Fujiwara, who helped during the trying war years; and currently Dr. I. L. Tilden, friend and advisor to HSMT.

Miss Martens has always been a worker for, and booster of both ASCP Registry and The American Society of Medical Technologists. She became the 1,507th member of the registry in 1933 and twice, in 1953 and 1957, attended the national convention of ASMT as the delegate from Hawaii. Besides serving one term, 1954-1955, as President of HSMT she has also served as Vice-president and has been publications editor many times.

Miss Martens' main hobbies have been her house and yard on Kapalama Ave; sewing, she makes most of her own clothes; painting, particularly the laboratory Christmas mural; and her little Austin, which she bought and learned to drive just two years ago. She has been an active member of the Good Shepherd Lutheran Church, where she is a member of the choir; she also sings alto with the Lutheran Singers.

I know that many of us will miss not only her advice stemming from years of experience and her example of selfless dedication to our profession, but even more, her patient and tolerent outlook on life and her wonderful sense of humor.

Aloha Miss Martens, though you may be leaving us in person you will never leave our memories and hearts.

V. J. COEN

Laboratory Manual of Pediatric Micro-Biochemical Techniques

By Donough O'Brien, M.D., M.R.C.P., and Frank Ibbott, F.I.M.L.T., University of Colorado, 1959.

This manual represents a valuable reference source for the busy clinical chemist or laboratory technician. Most of the techniques outlined have been time proven in hospital laboratories and in laboratories devoted to clinical research. The newer methods contained in the manual seem to be well chosen from the overwhelming mass of test and modifications of tests presented in the numerous laboratory journals. However, for some tests presented in this manual such as 17-keto steroids, 17-hydroxy corticosteroids, serum muco protein, and barbiturates, one wonders if the title micro-technique is well chosen, for these tests as presented, are at best semi-micro in nature.

It is also to be noted from a careful perusal of the manual that the full capabilities of some of the tests presented are not utilized. For example the barbiturate method of Golbaum may be utilized to differentiate the barbiturate on the basis of the 5,5′ substitution. If one is to take the trouble of extraction and U.V. spectrophotometry, he may as well go to the small additional trouble of discovering which barbiturate is present, especially if the test involves toxicologic analysis. Further, it is to be noted that all the barbiturates do not have the same extinction coefficient and as a result of the use of only one of the many barbiturates as the standard, the presented method has a serious built-in quantitative error.

If any laboratory outside a university hospital is to give serious thought to the use of this manual in toto as a laboratory work book or set of operating methods, difficulties certainly would be encountered in regard to the availability of such instruments as the Recco De Salter, the Polarograph, and the spectro fluorometer. In addition, any outlying hospital concerned with pediatric chemistry must give some thought to the availability of technicians trained to use these instruments as well as to some way to have the instruments repaired.

In addition those methods using polarographic techniques seem to be poorly presented.

In summary the manual seems to be another valuable book to have on the shelf in the laboratory for ready reference. Most of the presented tests are well known and this simply represents another compilation. A little more explanation as to the chemistry of the test and the reasons for some of the steps as well as more information as to clinical interpretation would be helpful.



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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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COUNTY SOCIETY REPORTS

(Continued from page 188)

would not recognize either motion at this time.

Dr. Devereux appealed to the Chair that Dr. Millard's motion was recognized and asked that attention be focused to the motion on the floor to rescind.

Dr. Richert reiterated, that at the present time, no motion had been recognized by him.

An appeal was made from the floor to appeal the ruling of the Chair and requesting that a vote be taken on whether or not the Chair had recognized Dr. Millard's motion.

The Chair then announced that he would entertain a motion to vote on whether he had recognized Dr. Millard's motion.

Following a vote by the membership, it was announced that the motion had failed to carry, 56 to 73.

A lengthy discussion followed with the members expressing their opinions freely. The following statements were taken from the meeting:

Dr. Chung stated that the action taken by the Society on paragraph 15 took out of context a portion of the Division of Surgical Fees report and that such action was to the detriment and disadvantage of a certain segment of physicians.

Dr. Nishigaya speaking as President of the Hawaii Medical Association appealed to the membership for a peaceful settlement of the problem. He stated that his aim as president this year was to try to bring the doctors closer together and that there was nothing the doctors

(Continued on page 212)

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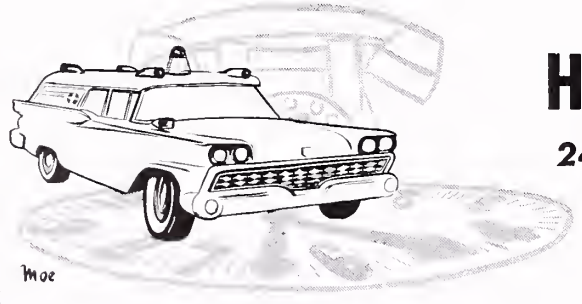
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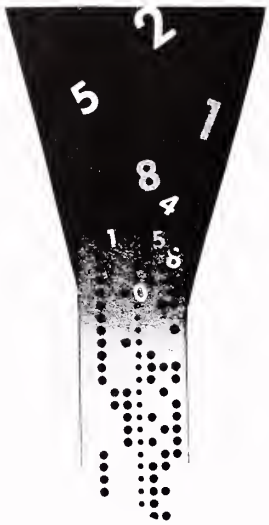
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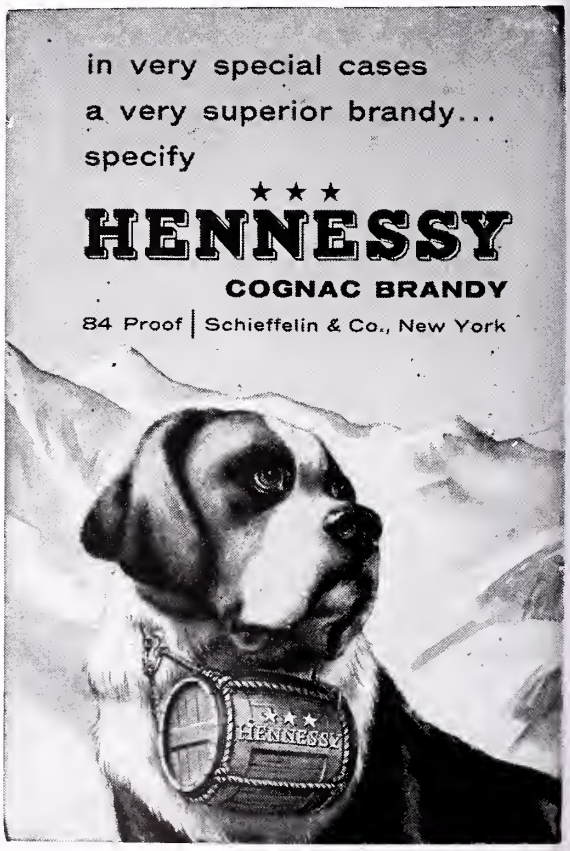
(Continued from page 183)

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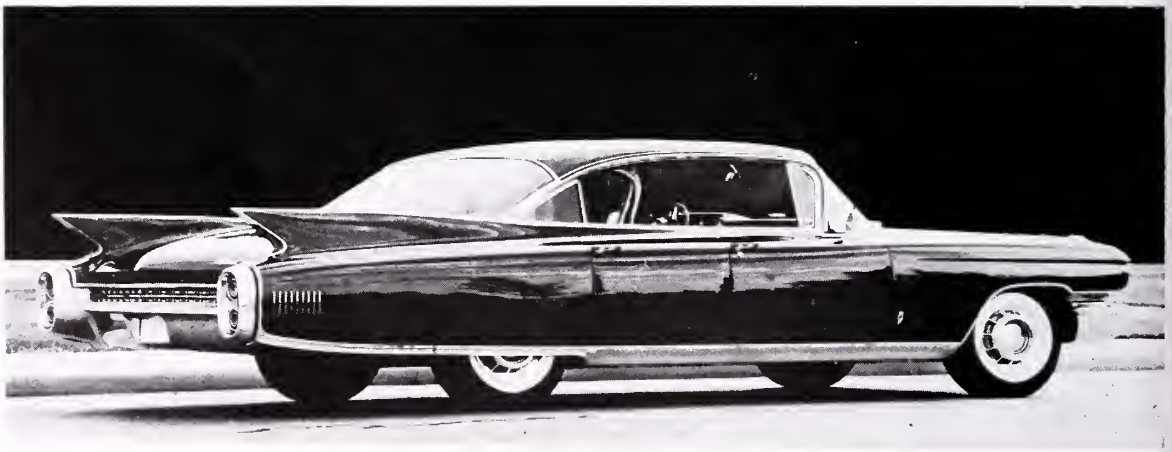


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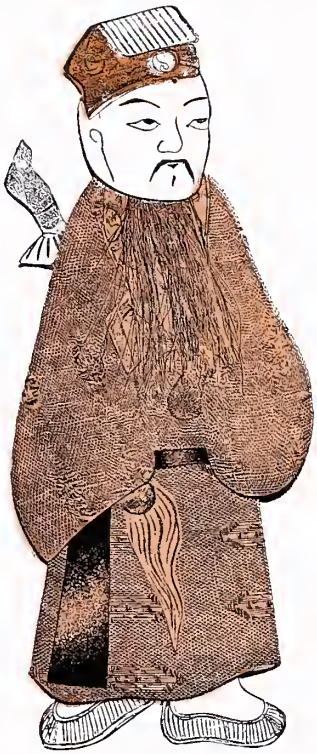
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COUNTY SOCIETY REPORTS

(Continued from page 206)

couldn't secure for themselves, as long as they presented a united front. He stated that there have been some vicious rumors and accusations circulated among the physicians about the general practitioners and he would like to disprove these rumors as being outright lies. All the general practitioners want, he stated, is what they feel they are entitled to and nothing more.

Dr. Gebauer, speaking as President of the Hawaii Chapter of American College of Surgeons, stated that under no circumstance should the surgical fee be split and every physician should be justly paid. It was their feeling that surgery should be performed by competent surgeons and that their remuneration should be just. He stated that the surgeons are willing to continue to go along with the present fee schedule as long as there are no further reductions and no splitting of fees.

Dr. Freeman noted that the action the membership took at the April meeting on section 15 was really to restore a rule that had been in operation for a considerable time and which had been changed. How it got changed, he didn't know, but it was important to note that HMSA has operated under a rule which was essentially no different than what was passed two months ago.

Dr. Marnie stated it was his personal opinion that the issue tonight was none other than money. It was his feeling that the Division of Surgical Fees report would not solve the problem at all. His solution to the problem would be to get out from under this participating physician's agreement with the insurance company and follow the Relative Value Schedule right down the line and

(Continued on page 223)

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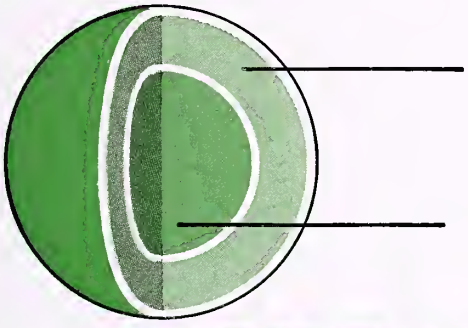
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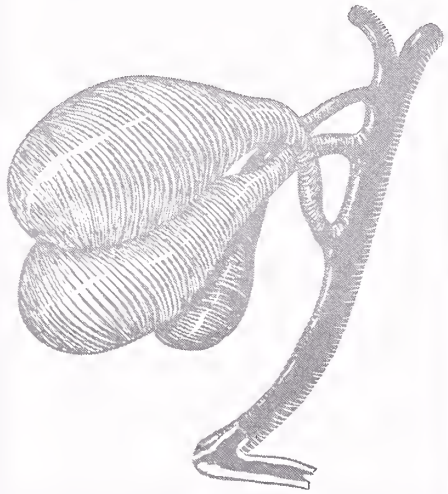
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Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



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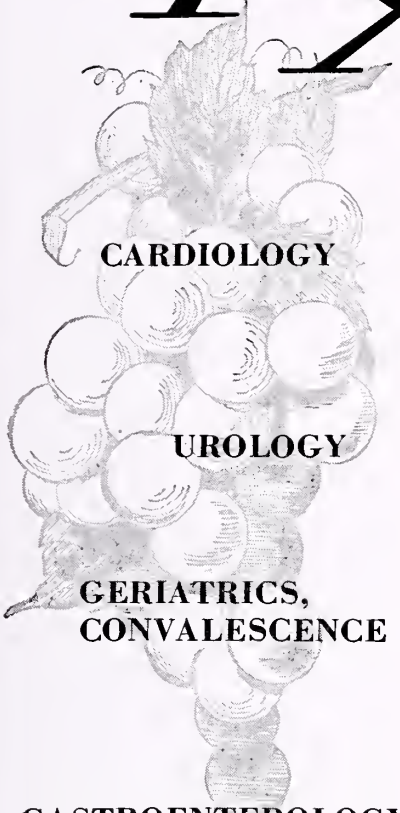
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(1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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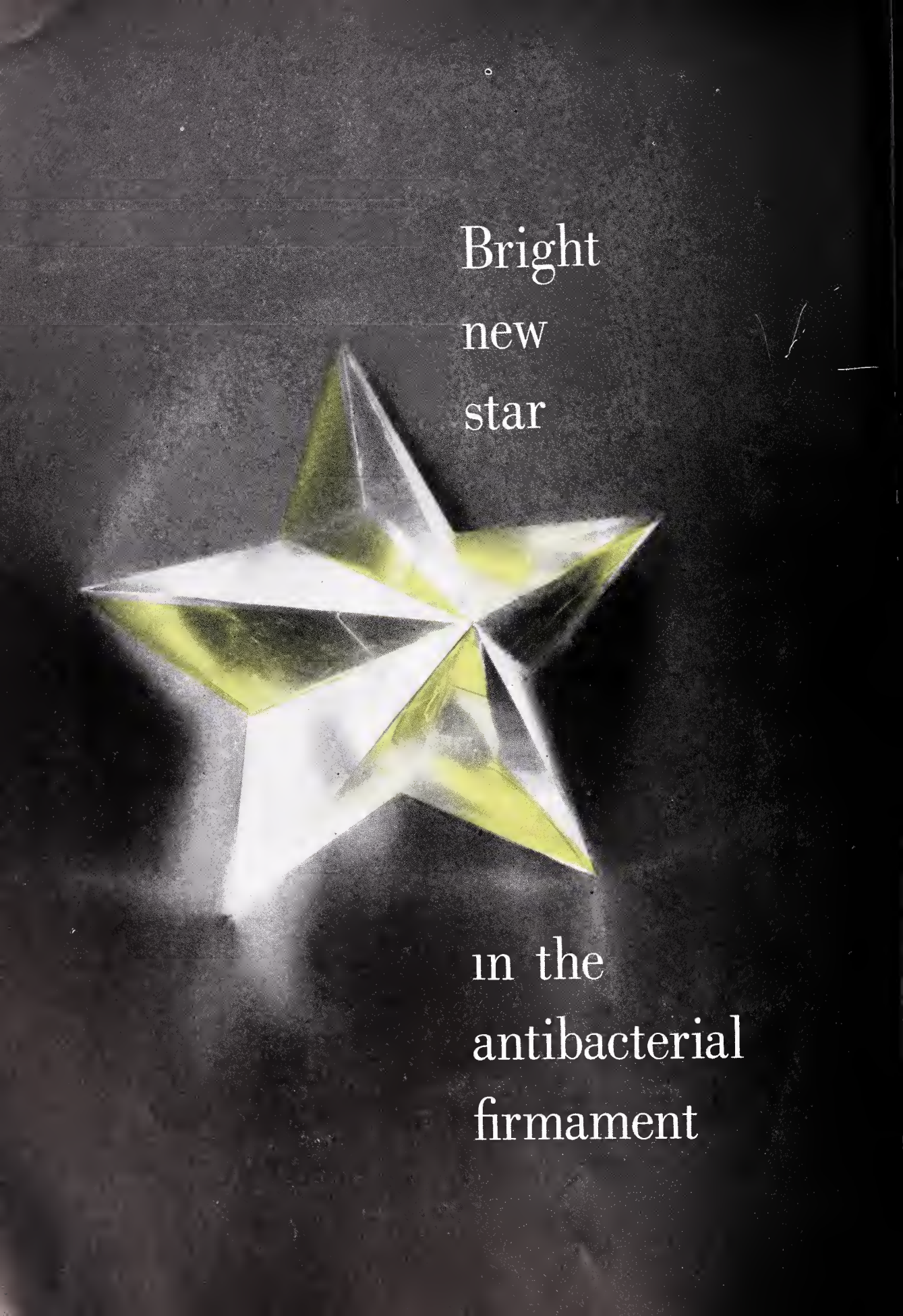
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Effective in vitro against the following organisms (isolated from clinical infections listed above):

Organism	*Sensitive*	*Resistant*	*% Sensitive*
Staphylococci*	181	1	*99.4*
Streptococci	65	1	*98.5*
D. pneumoniae	14	0	*100.0*
Coliforms	34	3	*91.8*
Proteus	5	5	*50.0*
A. aerogenes	8	0	*100.0*
Ps. aeruginosa	5	4	*55.5*

*Includes many strains resistant to antibiotics.

Tablets of 250 mg. (adult) and 50 mg. (pediatric)
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Both potencies in bottles of 60.

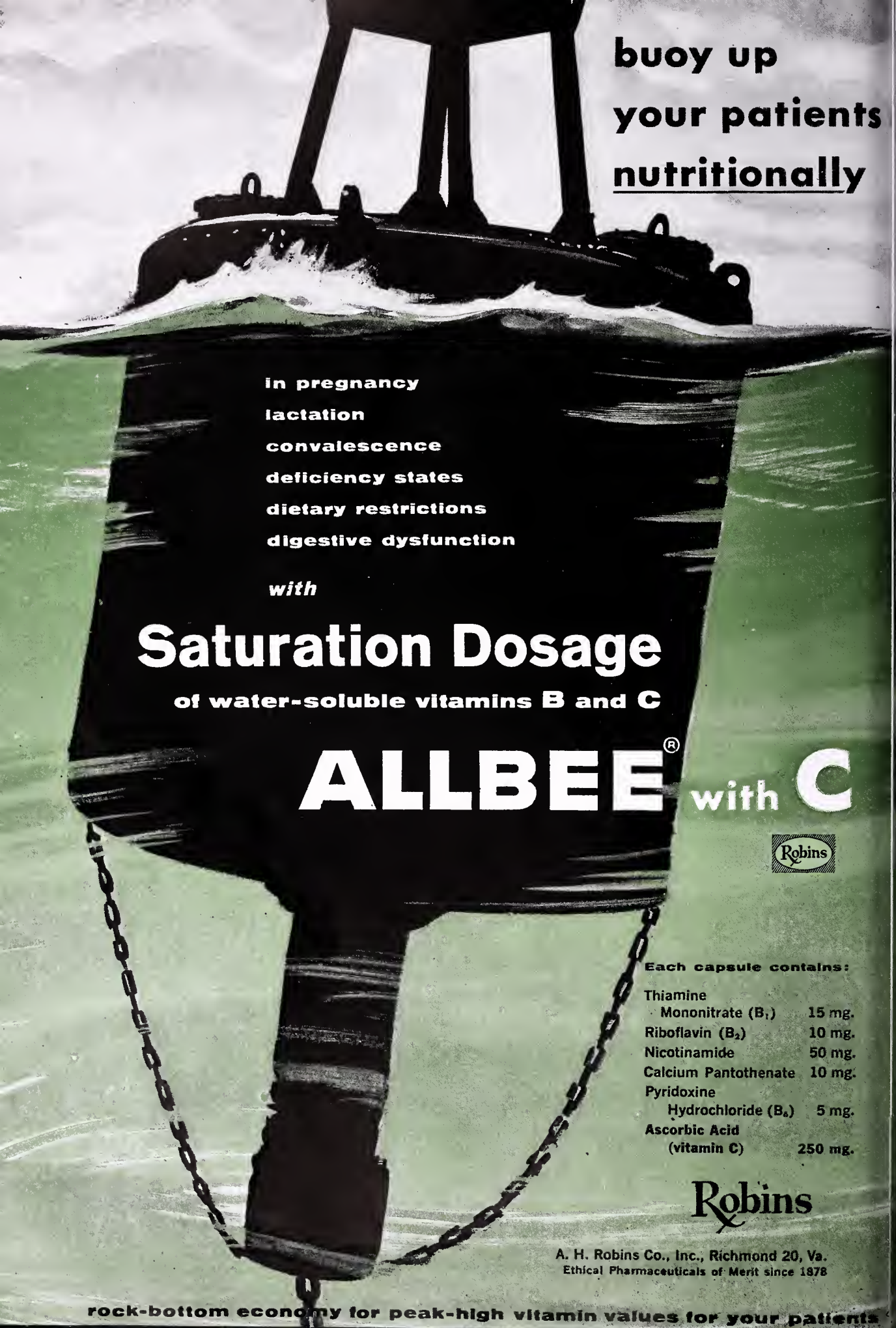
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Each capsule contains:
Thiamine Mononitrate (B_1) 15 mg.
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Adequate aspiration is one of those facilities which leave a good impression in the patient's mind, because of the comfort and ease of breathing it affords him. That calls for steady, power-controlled aspiration *when* — *where* — and *as long as it's needed.*

That's why so many hospitals, clinics and physicians specify GOMCO Aspirators. They can depend on them. You can depend on them, too, because they are built to a standard of craftsmanship that tolerates no flaws.

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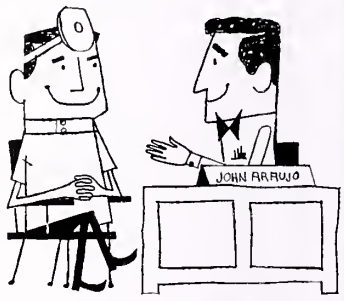
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COUNTY SOCIETY REPORTS

(Continued from page 212)

charge every insurance company the same fees.

Dr. Edmund Lee was of the opinion that the issue was not how much the surgeon gets or how much the general practitioner should get, but that all the general practitioner wants is to be remunerated for whatever services they give, and he would vote for the action to rescind and that paragraph 2 section 15 be left in status quo.

Dr. Moore stated that tonight's discussion was very helpful in that the two sides of the problem are not as far apart as everyone thinks. However, one thing you have to be sure of, and that is, you have to be clear in your thinking. There are two aspects of the problem to consider. One states that you "can't split a surgical fee" which is the ethical aspect, and in the Allison's report it states, "The laborer is worthy of his hire" which is economics. He stated that the doctors will have to decide whether they want more indemnification or more services. If you take the surgical fee schedule and put it on an indemnification basis, HMSA won't like this.

Dr. Jacobson brought up the question of the consultant. He stated that if the general man calls in the surgeon, it is still the general man's case and he has a perfect right to follow it up.

Dr. Nance suggested as a possibility that perhaps it could be estimated within each fee what covers the actual surgery performed and what part is for the aftercare, and then leave it up to the surgeon and general practitioner to decide what is considered aftercare. In answer to this suggestion, Dr. Moore stated that the

(Continued on page 241)



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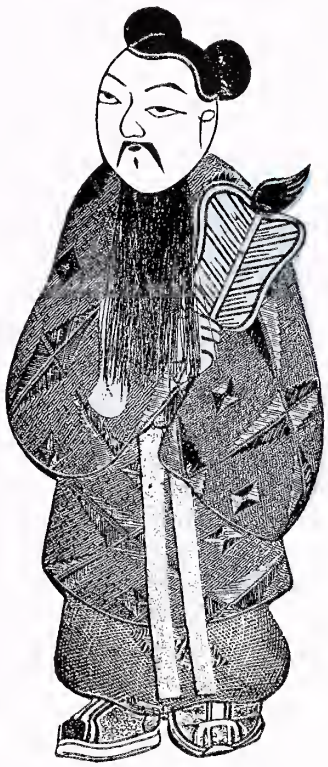
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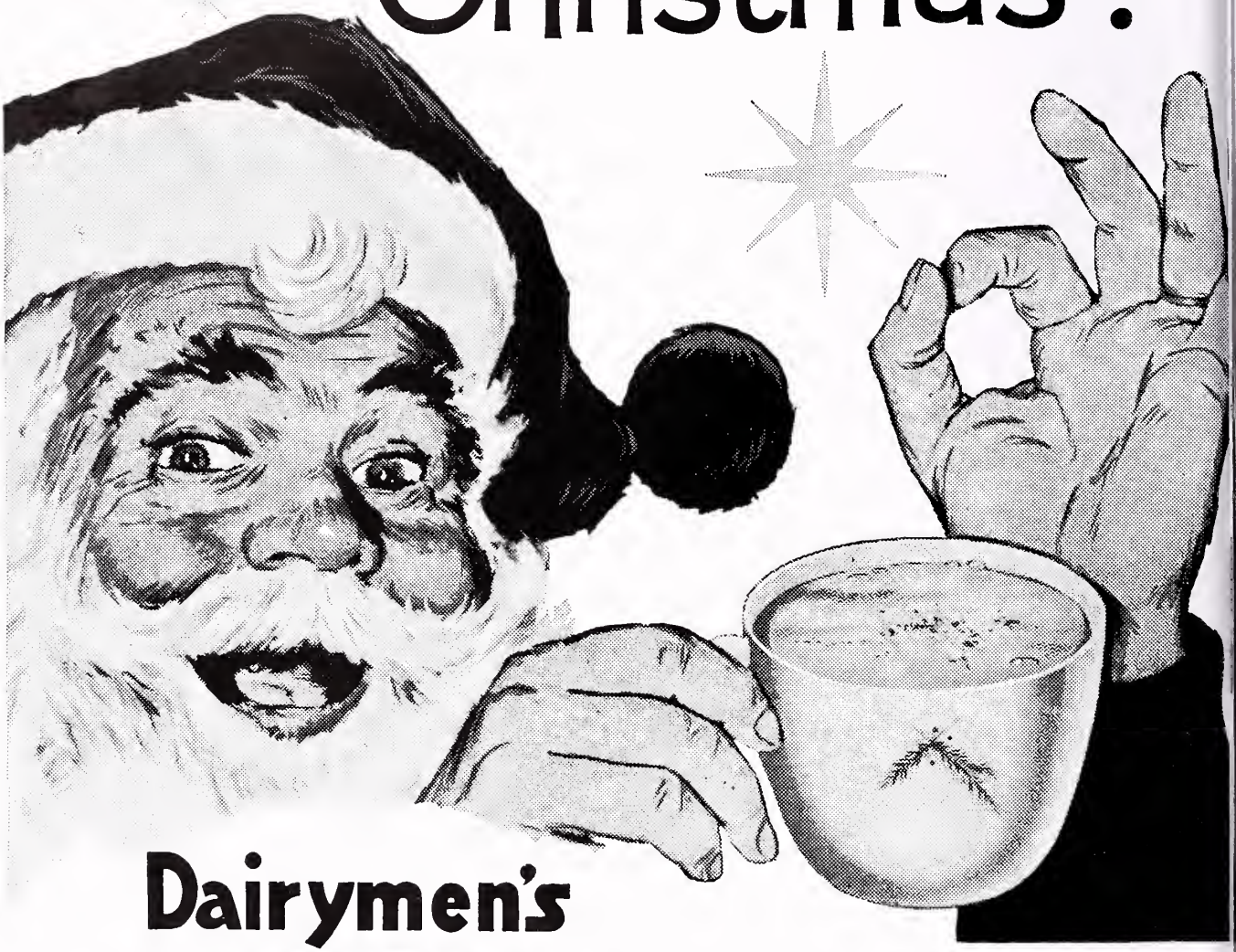
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1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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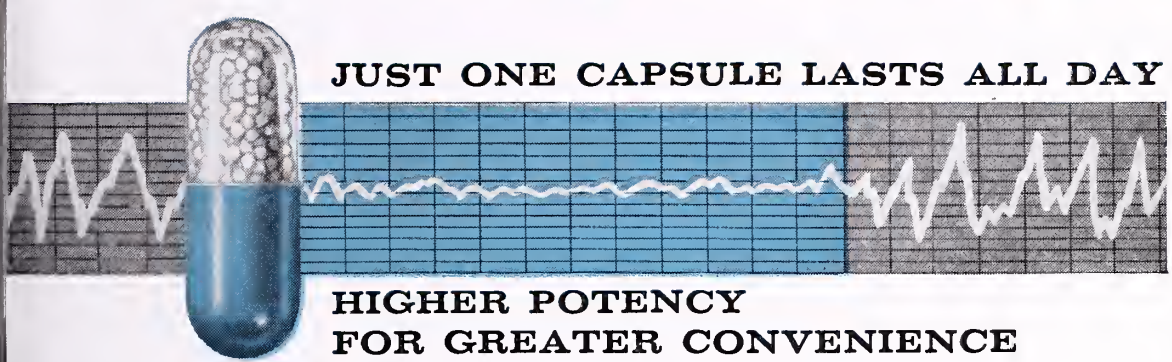
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- relieves *both* mental and muscular tension without causing depression
- does not impair mental efficiency, motor control, or normal behavior

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. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

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Cold Tablets

for "Syndromatic" Control of
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Neo-Synephrine now has three complementary compounds added to its own dependable, decongestive action for more complete control of the common cold syndrome.

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protection... through the full range of common cold symptoms

Each tablet contains:

for **NASAL STUFFINESS, TIGHTNESS, RHINORRHEA**

NEO-SYNEPHRINE HCl 5 mg...... First choice in decongestants for its mild but durable action and excellent tolerance.

for **ACHES, CHILLS, FEVER**

ACETAMINOPHEN 150 mg. ..... Dependable analgesic and antipyretic

for **RHINORRHEA, ALLERGIC MANIFESTATIONS**

THENFADIL® HCl 7.5 mg. ..... Effective antihistaminic to relieve rhinorrhea and enhance mucosal resistance to allergic complications.

for **LASSITUDE, MALAISE, MENTAL DEPRESSION**

CAFFEINE 15 mg.

DOSE: ***Adults:*** 2 tablets three times daily.
Children 6 to 12 years: 1 tablet three times daily.

Bottles of 20 and 100 tablets.

Neo-Synephrine (brand of phenylephrine) and Thenfadil (brand of thenyldiamine), trademarks reg. U.S. Pat. Off.

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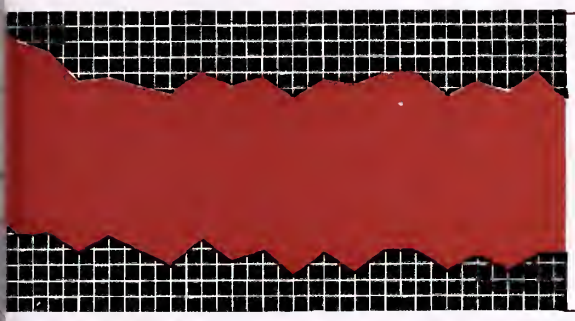
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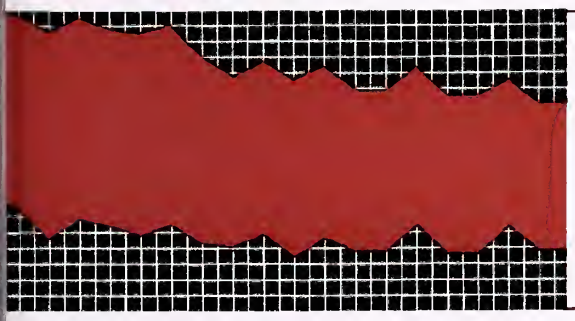
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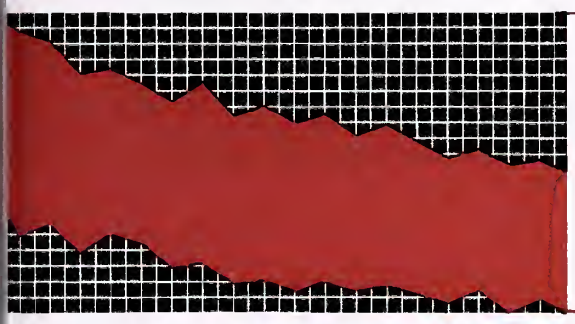
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- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
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- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

HYDROPRES-25

25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

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50 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one or two times a day.

If the patient is receiving ganglion blocking drugs or hydralazine, their dosage must be cut in half when HYDROPRES is added.

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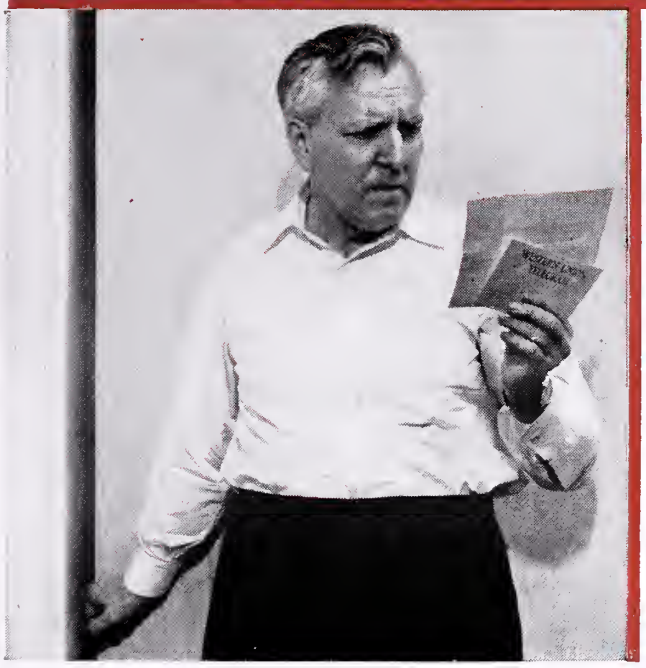
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Your high-strung angina patient often expends a "100-yd. dash" worth of cardiac reserve through needless excitement.





Curbs emotion as it boosts coronary blood supply

CONTROL OF EMOTIONAL EXERTION with Miltrate leaves him more freedom for physical activity.

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Miltrate*

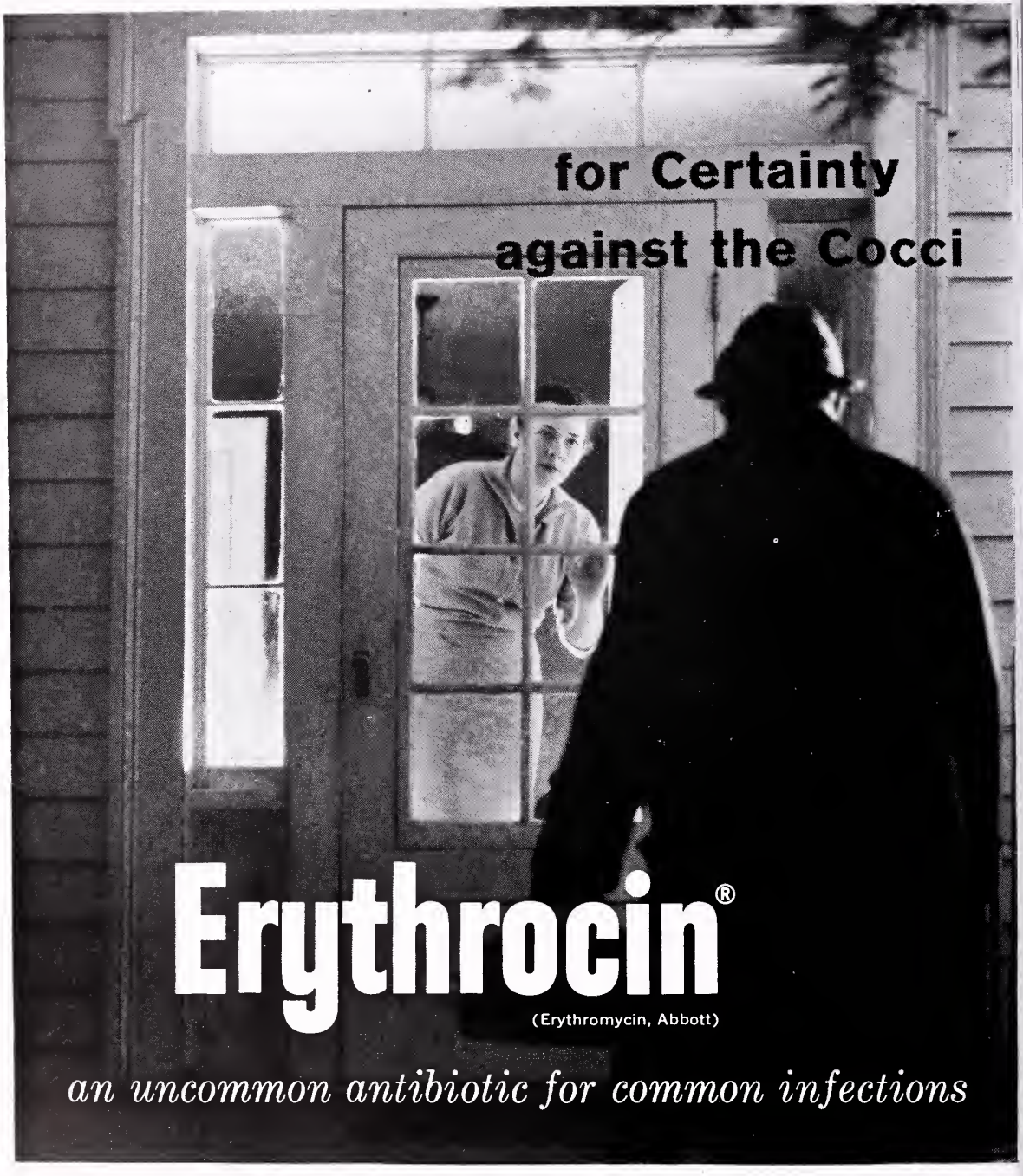
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Each tablet contains: 200 mg. Miltown and 10 mg. pentaerythritol tetranitrate.
Supplied: Bottles of 50 tablets.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime. Dosage should be individualized.



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for the tense and nervous patient

relief comes fast and comfortably

—does not produce autonomic side reactions
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Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

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make them measure up



Incremin® with iron Syrup

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help restore the normal blood picture—iron as ferric pyrophosphate to restore or maintain normal hemoglobin.

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upgrade low-grade protein—cereals and other low protein favorites of children, upgraded by l-Lysine, work with meat and other top protein to build stronger bodies.

tastes good! Each daily cherry-flavored teaspoonful dose (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	0.75%

Bottles of 4 and 16 fl. oz.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

OUNTY SOCIETY REPORTS

(Continued from page 223)

edical Care Plans Committee has considered this pos-
ility, but it still is fee splitting.

During the discussion Dr. Devereux moved to rescind e action taken by the membership at the April 7 meeting on Section 15. The motion was seconded by Dr. wrence Lau and was duly recognized by the Chair.

Immediately following, Dr. Freeman moved to table r. Devereux's motion which was seconded by Dr. Allin. This motion to table was defeated, 56 to 70.

A motion made by Dr. Robert Chung to recess for 10 inutes, which was duly seconded, was lost by a major- vote.

A motion made by Dr. Palma to adjourn the meeting as duly seconded and was lost by a majority vote.

Dr. Nishigaya speaking in favor of Dr. Devereux's otion to rescind the action of April 7 reiterated that e general practitioners as a whole did not know what as going on at that meeting and all they are trying to is to rescind the matter back to a status quo. He appealed to the membership to permit a negotiating committee to sit down in conference together and settle this atter amicably.

Dr. Warshauer asked Dr. Devereux if he would consider an amendment to his motion to include such a mmittee as Dr. Nishigaya suggested.

Dr. Devereux stated that he did not feel that this atter could be resolved in the near future, that somew this matter can be worked out. Therefore, he could ot accept Dr. Warshauer's request.

Following further pro and con discussion as to

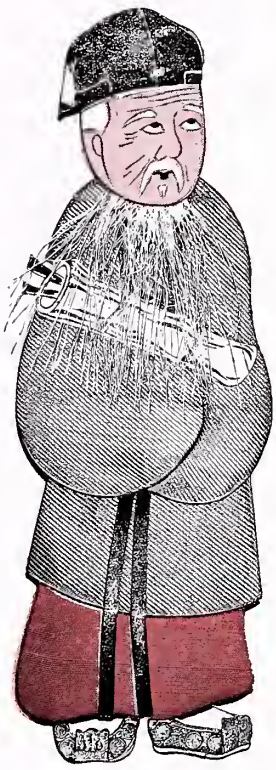
(Continued on page 242)

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COUNTY SOCIETY REPORTS

(Continued from page 241)

whether a negotiating committee would be able to resolve the matter, the motion on the floor was called for a vote.

A motion made by Dr. Glover for a secret ballot was put to a vote, but was lost by a majority vote.

Dr. Devereux's motion to rescind the action taken at the April 7 meeting was then voted on and was lost by a vote of 70 to 84.

Dr. Moore stated that now the Society has resolved the ethical principles he felt that the Medical Care Plans Committee would be perfectly willing to sit down with representatives from the surgical group and the general practitioners group to work out the economic principles on an economic basis.

It was called to the attention of the membership that we are to instruct our Medical Care Plans Committee to negotiate with HMSA to put this into effect, that is, the report of Dr. Allison's Committee, and the vote of this body at the April 7 membership meeting.

In closing Dr. Allison moved the adoption and acceptance of Items I, II, III, IV and VI of the Division of Surgical Fees Committee's report which had not been acted upon. The motion was seconded and was passed.

There being no further business, the meeting was adjourned.

T. H. RICHERT, M.D.
President
For Dr. A. S. Hartwell

Maui

The Maui County Medical Society meeting was called to order at 8:00 P. M. by the President, Dr. L. T. Kashiwa, on Tuesday, April 21, 1959, at the Central Maui Memorial Hospital.

Dr. Sanders moved and Dr. Underwood seconded that the Secretary be instructed to write to the *Maui News*, M. C. C. Young of the *Star-Bulletin*, and M. Louis Head of *The Honolulu Advertiser* requesting that names of doctors be omitted from newspaper articles on medical and surgical cases. Motion was unanimously passed.

* * *

The Maui County Medical Society meeting was called to order at 8:15 P.M. by the President, Dr. L. T. Kashiwa, on Tuesday, May 19, 1959, at the Central Maui Memorial Hospital. Guests present were: Doctors Kliewer, Pfaeltzer, and Charles S. Cameron.

Dr. Cameron gave a very enlightening talk on "Cancer, Today's Big Problem."

Dr. Tong thanked the Society for the work done by the Society to get a psychiatrist for Maui County .

The meeting was adjourned at 10:25 P.M.

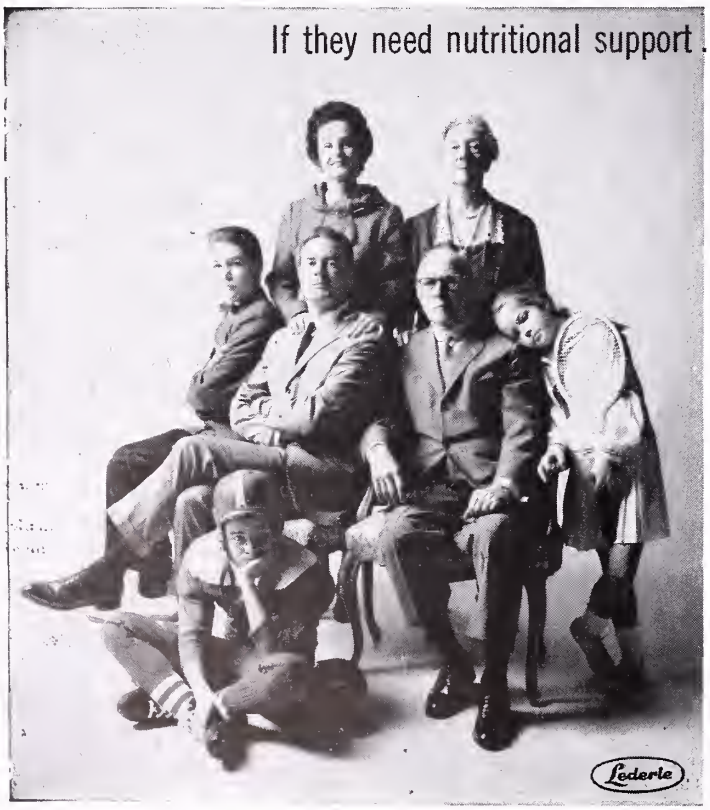
* * *

The regular meeting of the Maui County Medical Society was called to order at 8:00 P.M. by the President Dr. L. T. Kashiwa, on Tuesday, June 17, 1959, at the Central Maui Memorial Hospital. Ffteen members were present. Guests present were: Dr. Kliewer, Mr. Abe Fraga, Chief Narcotics Investigator of the Department of Health, Mr. William Grady, Federal Narcotics Bureau; and Mrs. Orpha Wong, Pharmacist, Central Maui Memorial Hospital.

A film "Someone is Watching" was shown by Mr. Fraga. He spoke on the careful handling and safekeeping of narcotics in conjunction with the above showing.

Mr. Grady also spoke on the dispensing of narcotics.

A. Y. WONG, M.D.
Secretary



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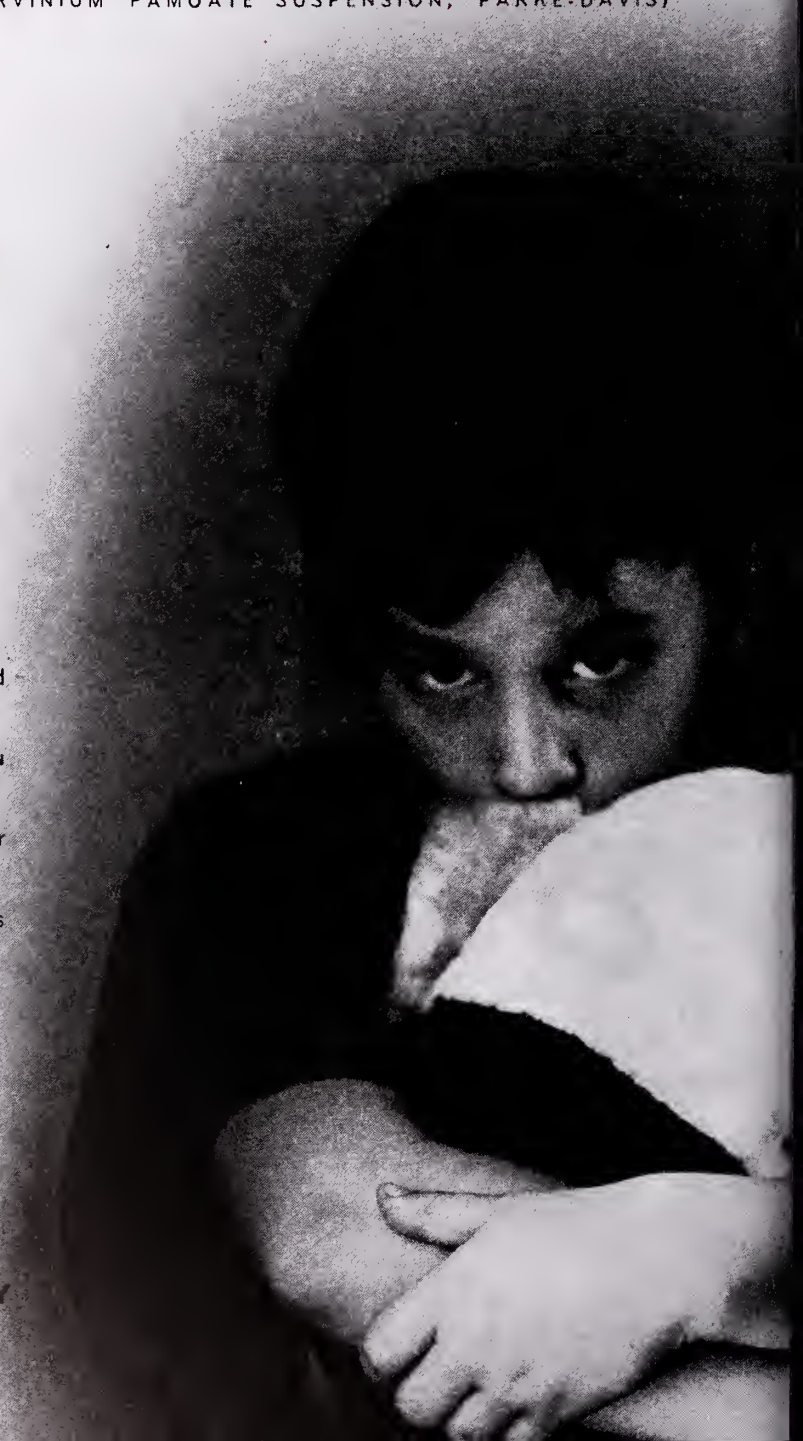
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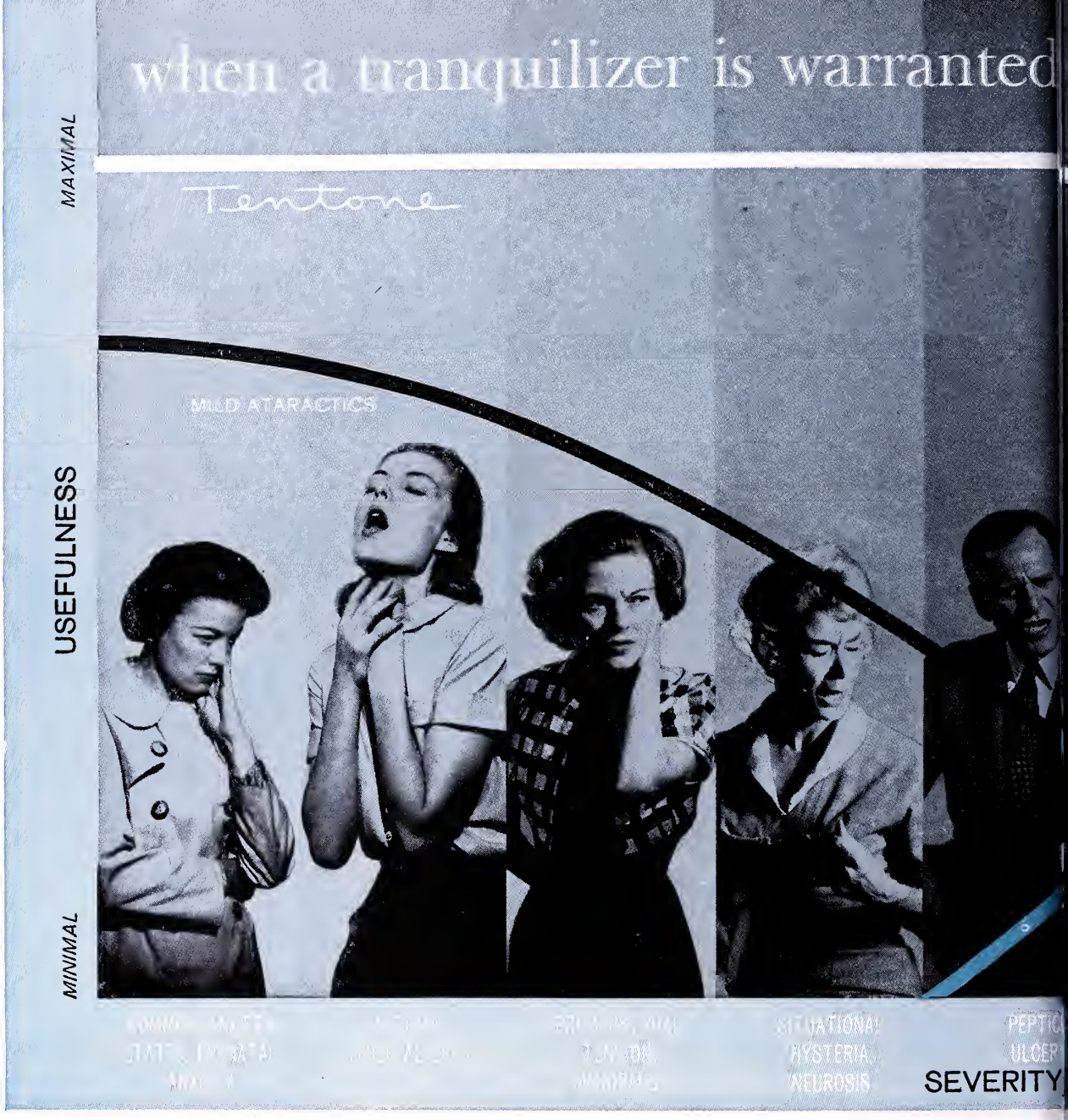
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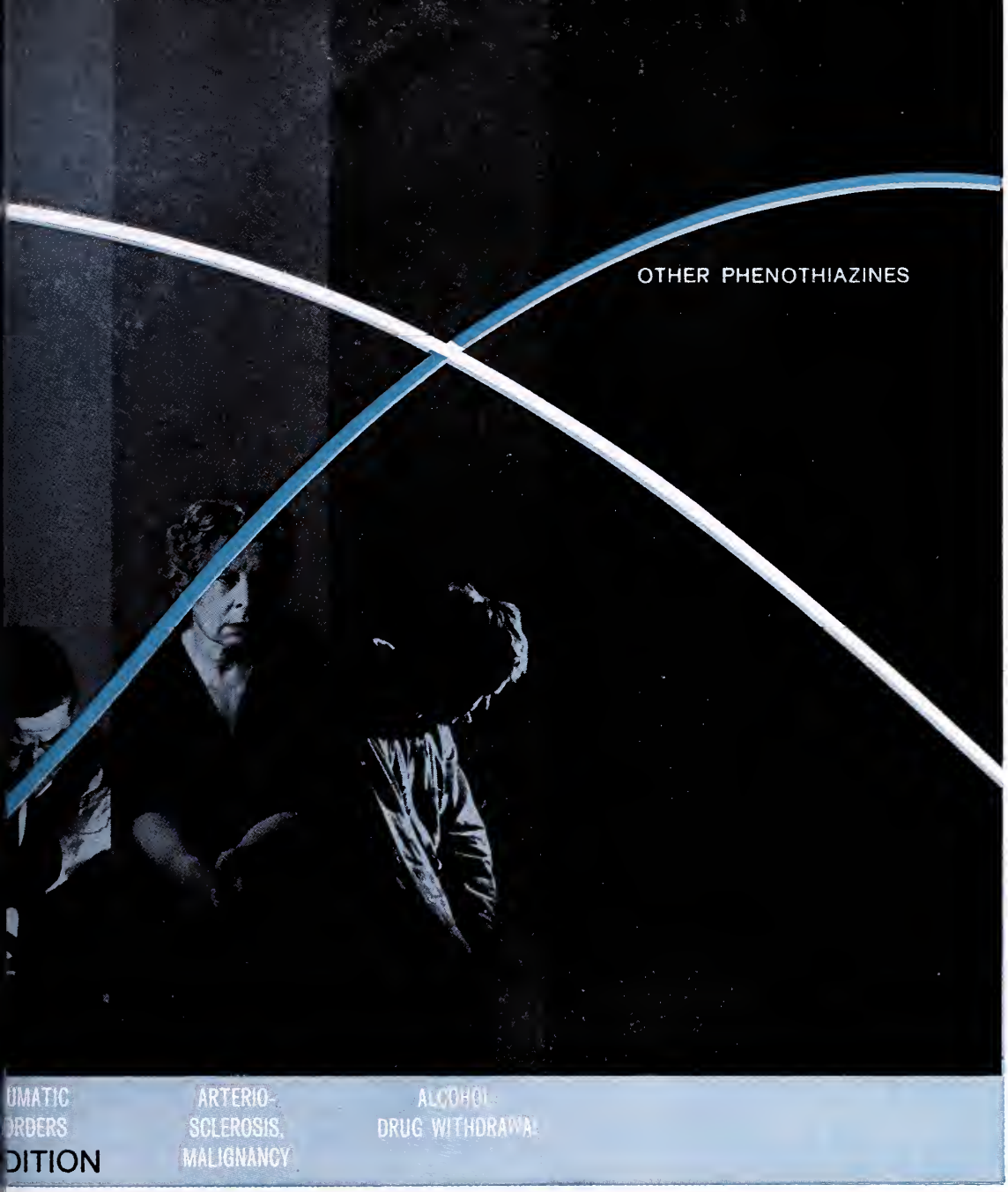
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References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschan H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavic A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 195

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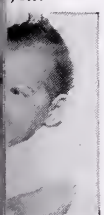
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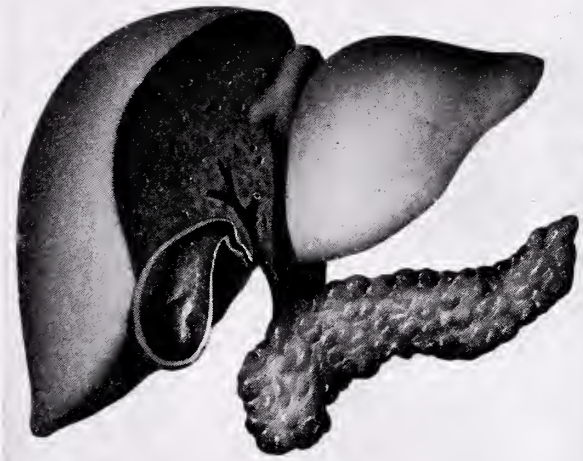
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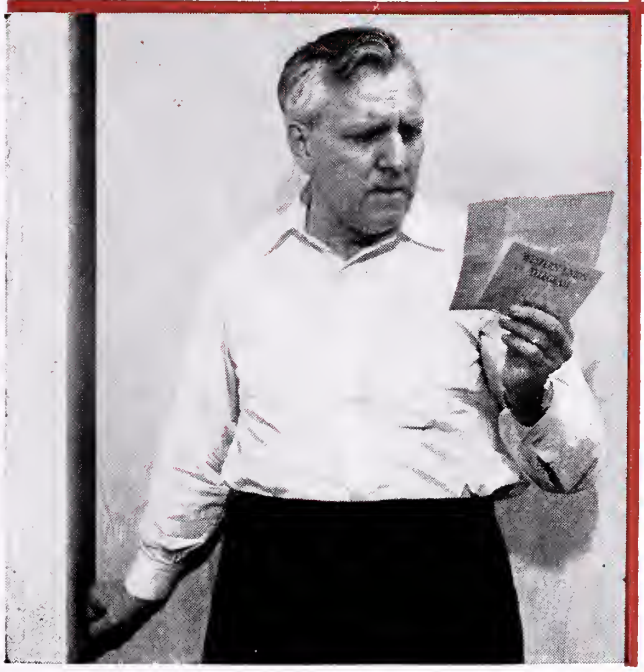
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Hawaii Medical Journal

VOLUME 19
NUMBER 3
JANUARY-FEBRUARY, 1960

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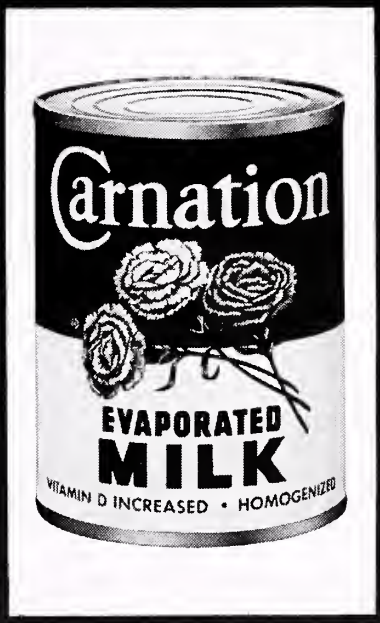
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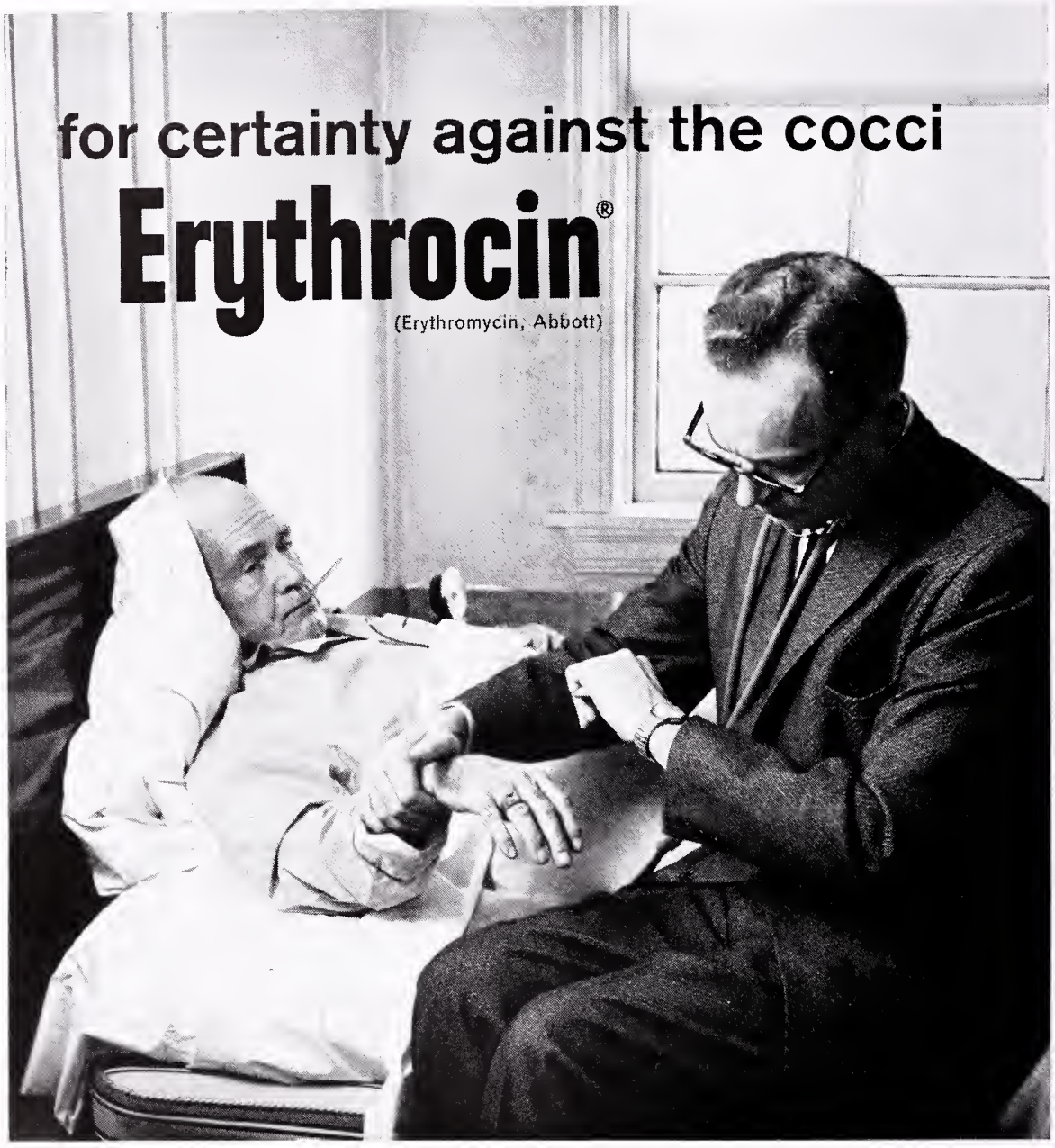
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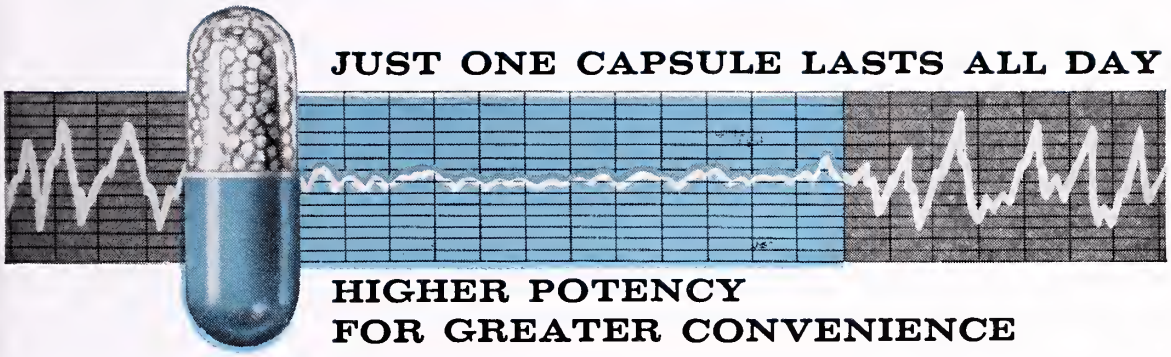
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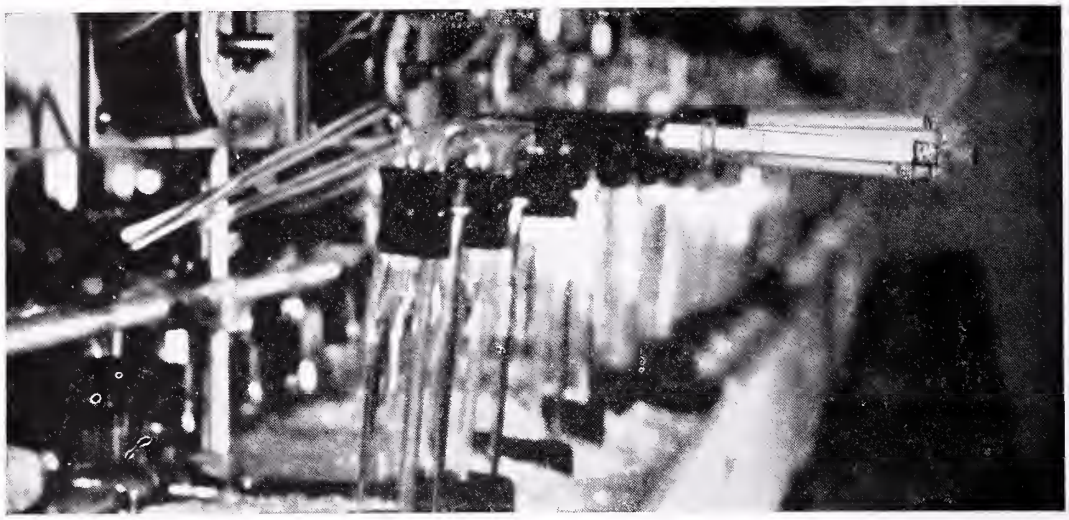
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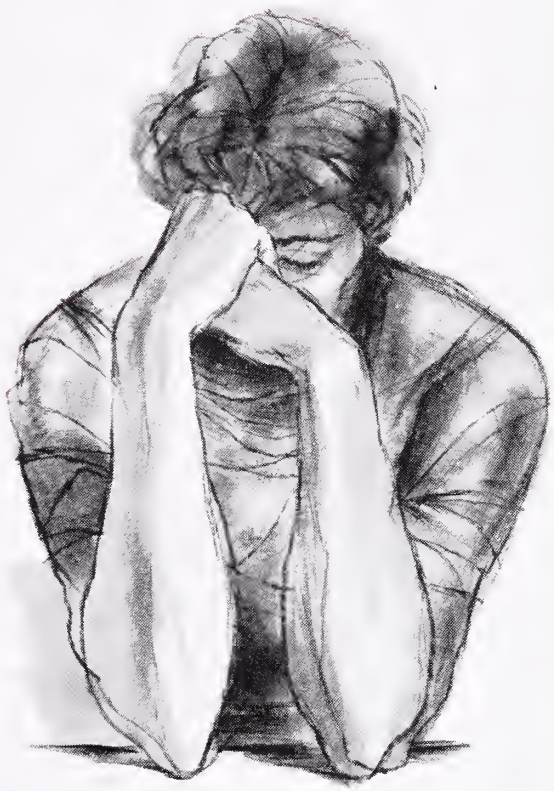
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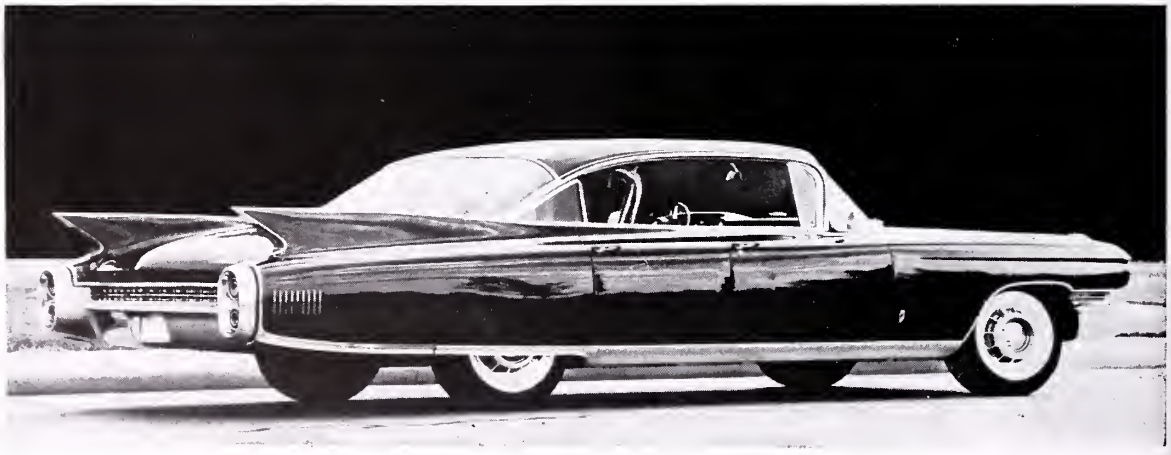
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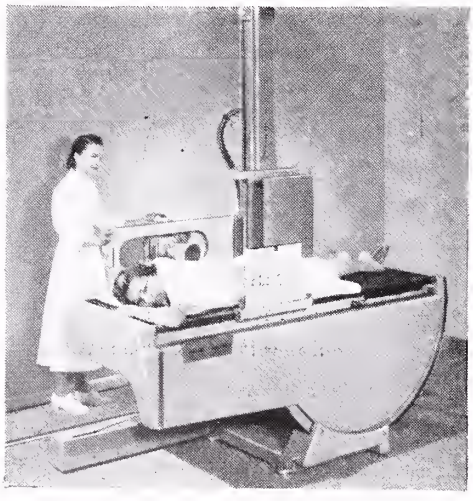
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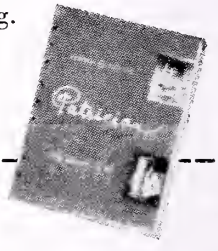


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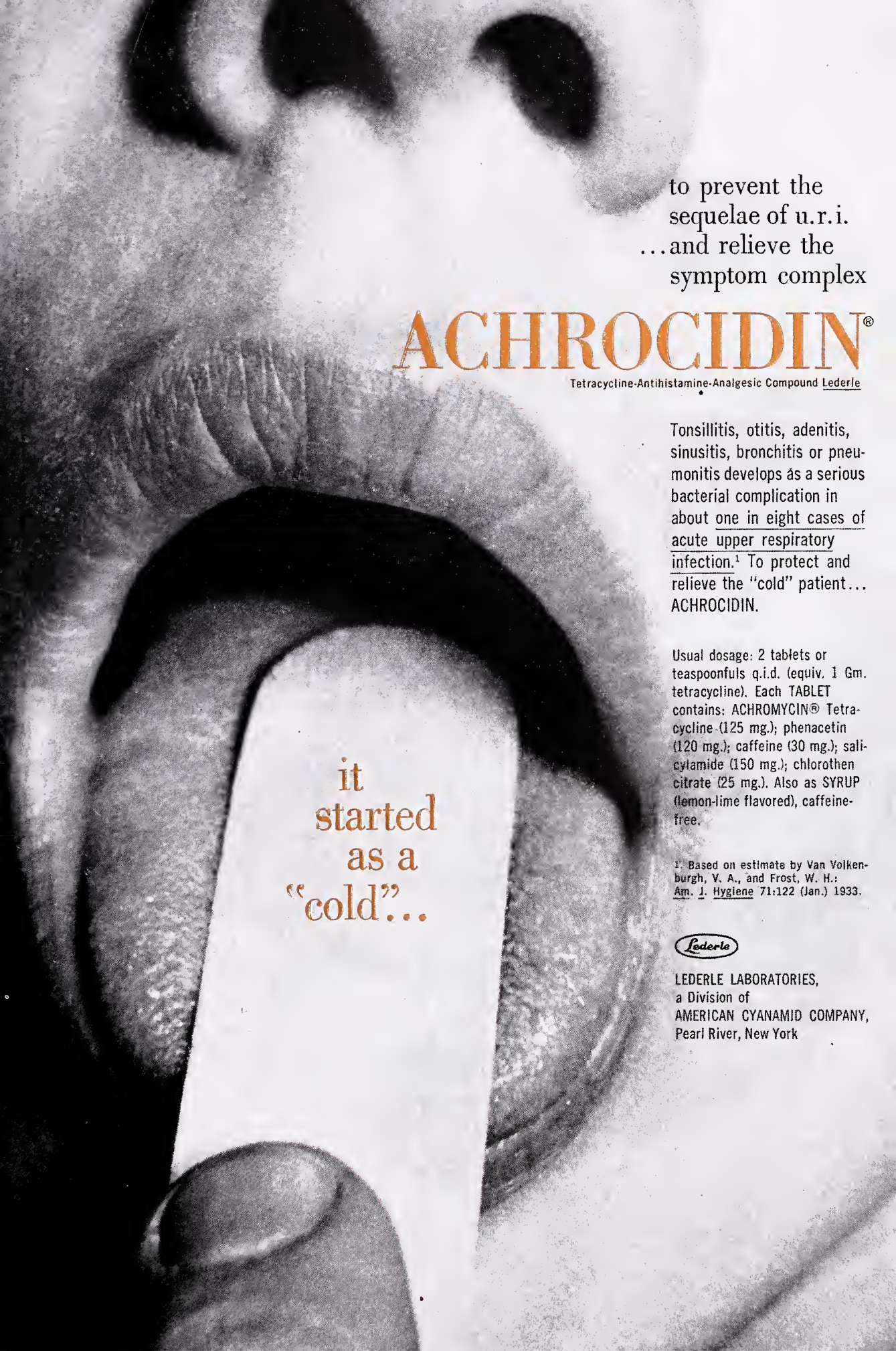
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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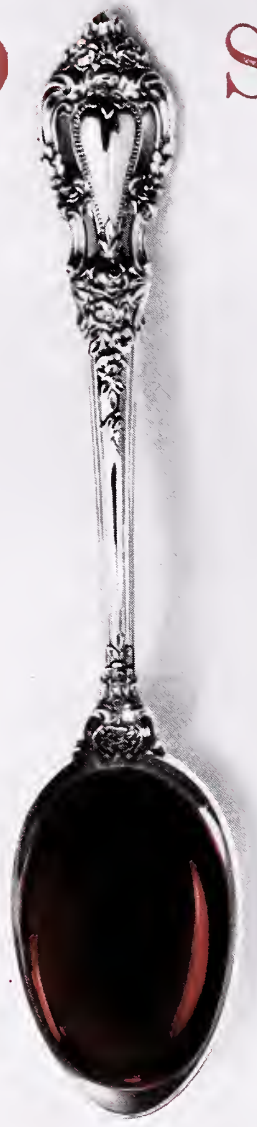
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References: 1. Cass, L. J., and Frederik, W. S.: Am. Pract. & Digest Treat. *2*:844, 1951. 2. Blanchard, K., and Ford, R. A.: Journal-Lancet *74*:443, 1954. 3. Hayes, E. W., and Jacobs, L. S.: Dis. Chest *30*:441, 1956. 4. Blanchard, K., and Ford, R. A.: Rocky Mountain M. J., Vol. 52, No. 3, 1955. 5. Boyd, E. M., and Pearson: Am. J. M. Sc. *211*:602, 1946.

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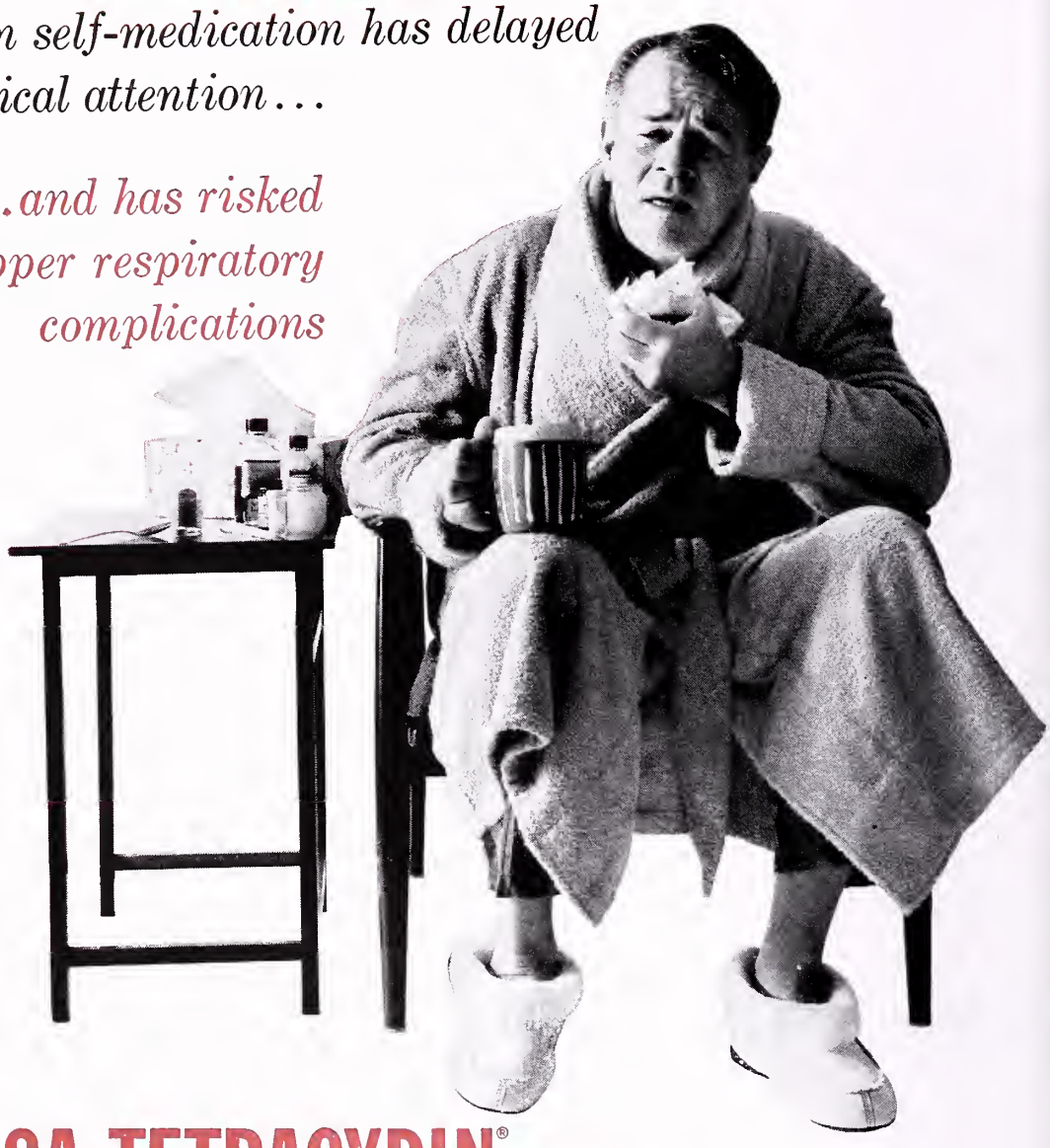
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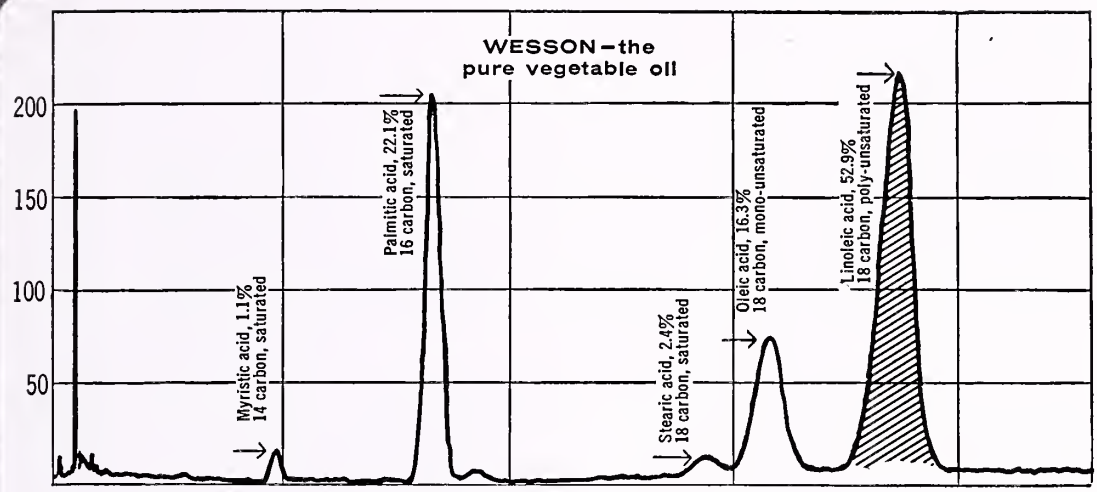
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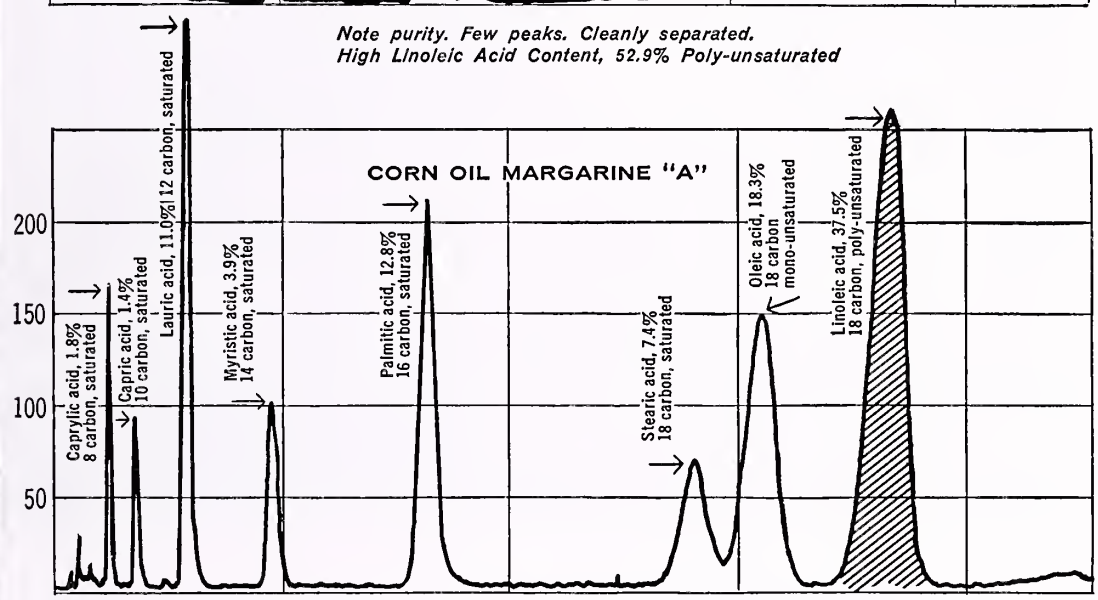
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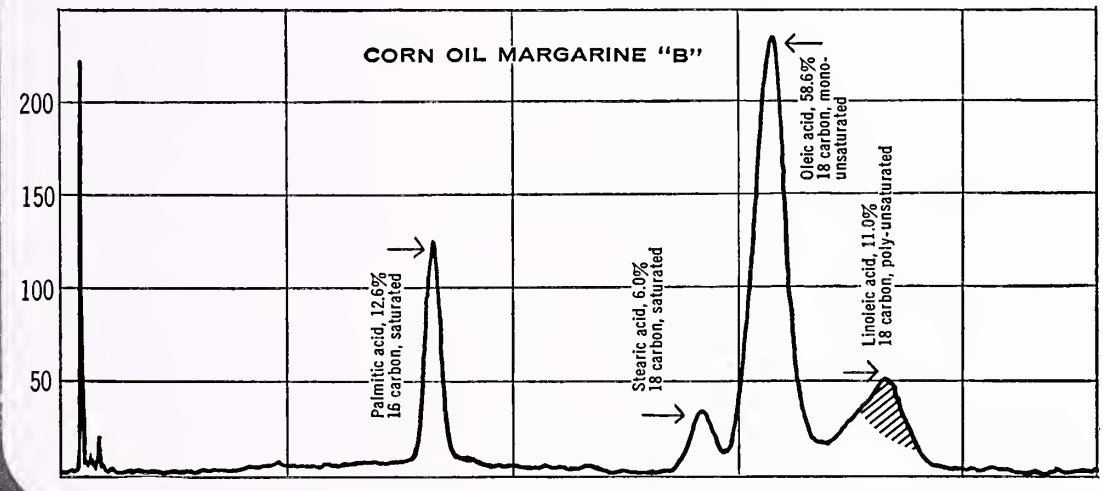
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Duodenal ulcers are caused by vagotonus and their treatment is medical; gastric ulcers are produced locally and are surgical problems from the start because medical therapy is ineffective and cancer cannot be ruled out

Gastric and Duodenal Ulcers

A Need for Emphasizing Their Dissimilarities

J. E. STRODE, M.D.,* Honolulu

LONG ASSOCIATION with the problems to be considered in the handling of patients suffering from ulcerating lesions of the stomach or duodenum impresses one with the fact that there are many differences between these diseases in respect to both cause and treatment. The young physician whose experience with these conditions has been limited, and older practitioners who have not been particularly interested in these problems, may not appreciate this fact. For these reasons, it is believed that a discussion of this subject may serve a useful purpose.

"Peptic" Ulcers

Gastric and duodenal ulcers are commonly referred to as peptic ulcers. Stedman's medical dictionary defines peptic ulcer as follows: "An ulcer of the mucous membrane of the stomach or duodenum caused by the action of the gastric juice upon a portion where the nutrition has been interfered with in some way." A more common interpretation of this term is that of Ivy and colleagues. They say: "A peptic ulcer is a benign nonspecific ulcer located in that portion of the alimentary tract bathed by gastric juice."

While for all practical purposes ulcers of the duodenum are always benign, one can never refer to a gastric ulcer as being benign with any degree of assurance. Therefore to group gastric and duodenal ulcers as "peptic ulcers" is misleading, and the term should, in the interest of safety and accuracy, be discarded. The roentgenologist, especially, should refrain from reporting his findings as showing the presence of a "peptic ulcer" of the stomach. Such a report tends to lull the physician responsible for the care of the patient into a false sense of security.

Etiologic Factors Dissimilar

The etiology of benign gastric and duodenal ulcers has been debated over the years, and no doubt unanimity of opinion will never be reached regarding many aspects of this subject. There seems to be uniform agreement that such ulcers are caused by the acid-pepsin secretions of the stomach, and all therapeutic efforts, both medical and surgical, are based on attempting to eliminate or reduce gastric acidity. It seems doubtful if such ulcers ever develop in the presence of complete anacidity of the stomach.

Much investigative work, both on the experimental animal and clinical observations in man, has been recorded, attempting to explain why gastric and duodenal ulcers develop, without anyone's bringing forth a completely satisfactory answer. The evidence appears quite conclusive that the principal factor in the production of duodenal ulcer is over-stimulation of the vagus nerves, of central or cephalic origin. This vagal stimulation results in over-production of hydrochloric acid in the gastric secretion. At the same time, this vagal stimulation causes increase in gastric peristalsis, resulting in large amounts of acid gastric juice being secreted and dumped into the

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duodenum in a comparatively short period of time. The duodenal mucosa not being resistant to such an overwhelming amount of acidity, an ulcer may develop. Since duodenal ulcers are most frequently encountered in individuals who live under a considerable amount of nervous tension and stress, the condition may be classified with other psychosomatic disorders.

The investigative work done to determine the etiology of benign gastric ulcers indicates an entirely different mechanism. The evidence seems quite convincing that these ulcers result from increased gastric acidity from overstimulation by food of the antral gastric mucosa. This stimulation of the antral mucosa results in the production of an enzyme, gastrin, which is absorbed into the blood stream, and this stimulates the parietal cells of the glands of the body of the stomach to overproduce hydrochloric acid. Any condition giving rise to hypoperistalsis or obstruction to the outlet of the stomach is prone to give rise to a gastric ulcer by prolonging contact of food with the mucosa of the antrum.



Bauer

DR. STRODE

Another physiological activity of the antral gastric mucosa that has been amply proved on the experimental animal, as well as by operative procedures formerly recommended for the treatment of the ulcers under discussion, is that after the gastric content reaches a certain degree of acidity, an anti-enzyme is formed that inhibits the further production of hydrochloric acid. This would seem to explain why pyloric exclusion operations, in which the antral mucosa is left in situ, have proved so unsatisfactory in the treatment of duodenal ulcers: the retained mucosa of the antrum is bathed in alkaline regurgitated duodenal content, an anti-enzyme is not formed, gastric acidity continues high, and a recurrent ulcer is likely to occur. Many years ago, when the Devine pyloric exclusion operation enjoyed a brief period of popularity, I did 12 of these procedures, but my enthusiasm ended abruptly when one of the patients a few weeks postoperatively developed a stomal ulcer which perforated, resulting in generalized peritonitis from which the patient died. Strange as it may seem, another patient developed a stomal ulcer five years after a gastroenterostomy, had the ulcer along with the antrum excluded, and now after twenty years continues to enjoy good health. Gastric physiology at times seems to be an individual affair, and no doubt many of its problems will remain an enigma for years to come.

Age Incidence Differs

Duodenal ulcers occur more commonly in the younger age group, while gastric ulcers much more commonly occur later in life, when cancer of the stomach is most frequently met. Twenty-seven years ago, I performed a gastroenterostomy on a Chinese boy of nine for marked pyloric obstruction secondary to a duodenal ulcer. Three months later, he developed a stomal ulcer requiring a high gastric resection. A number of years ago, a baby of nine months developed a profusely bleeding duodenal ulcer unresponsive to multiple blood tranfusions. In desperation, to control the bleeding, a gastric resection was done in which I assisted. Both of these individuals have remained well and have gone on to normal development.

Duodenal ulcers, while not common in infants and children, do occur much more commonly than gastric ulcers. The youngest individual for whom I have resected the stomach for a gastric ulcer was 12 years of age. Duodenal ulcers are very frequently encountered in the second and third decades of life, gastric ulcers more rarely. Both conditions, for unknown reasons, occur more commonly in males.

Proper Treatments Contrasted

Duodenal ulcers, as everyone agrees, are initially a medical problem, and surgery is only indicated for the treatment of their complications. There is much divergence of opinion regarding when and how these complications should be treated surgically. Most duodenal ulcers respond well to medical treatment, if given early, and if recognized methods of therapy are employed and the patient is cooperative.

Gastric ulcers, in my opinion, are surgical problems once the diagnosis has been made. The only contraindications to this method of therapy are physical unfitness of the patient for gastric resection, or unavailability of persons adequately trained and equipped to deal with this type of surgery. Space does not permit a detailed discussion to emphasize the points making such a conclusion tenable, but they are based on what seems, to me, irrefutable evidence of their soundness. They have been presented in other publications more completely.[1] Very briefly, the most important ones are:

[1] Strode, J. E.: In support of surgical removal of small ulcerating lesions of the stomach without benefit of medical treatment. Surg., Gynec. & Obst. 98:607 (May) 1954.
Gastric ulcer, a surgical problem. A.M.A. Arch. Surg. 75:202 (Aug.) 1957.

1. No one can be sure by any method or combination of methods of examination now at our disposal that an ulcer of the stomach is benign. X-ray and gastroscopic examination and cytological studies of gastric washings are the most useful methods of investigation, but they still leave a considerable percentage of early cancers unrecognized.

2. A follow-up study of large series of benign gastric ulcers treated medically reveals the fact that the majority are never permanently cured; probably only 25 or 30 per cent are relieved of symptoms. During this time there are a number of serious complications that may arise.

3. Gastric resection for benign gastric ulcer is a very safe and, for the most part, a very satisfactory procedure.

Surgical Treatment of Duodenal Ulcers

The elective surgical treatment of medically unmanageable duodenal ulcers has undergone many changes, and as yet no universally accepted method is recognized. Gastroenterostomy some thirty or forty years ago was almost unanimously accepted as the procedure of choice, and it took many years before it was finally established that recurrent ulcers occurred too frequently to make this a justifiable operation for this condition. One of my patients following gastroenterostomy was well for 29 years before a stomal ulcer developed requiring further surgical intervention, and several others had a similar experience after many years. Any new procedure for the treatment of duodenal ulcers will require extensive application and subsequent years of observation to prove its merit.

Following abandonment of gastroenterostomy, gastric resection came into vogue, the majority of surgeons concluding that 70 per cent or more of the stomach should be removed to insure against recurrence. This led to fewer recurrences but increased the number of individuals suffering from postoperative so-called dumping symptoms. Many surgeons still maintain that this is the operation of choice. Both Billroth I and Billroth II anastomoses have their advocates, with most observers believing there are more recurrences of ulcers with the Billroth I method, but perhaps fewer physiological disturbances in digestion. Difficulty in dealing with a scarred duodenum is another factor frequently making a Billroth I operation inadvisable.

Dragstedt favors gastroenterostomy with a small stoma in the antral region combined with bilateral vagotomy in the elective surgical treatment of duodenal ulcers. Others favor pyloroplasty over gastroenterostomy. A number of surgeons seem

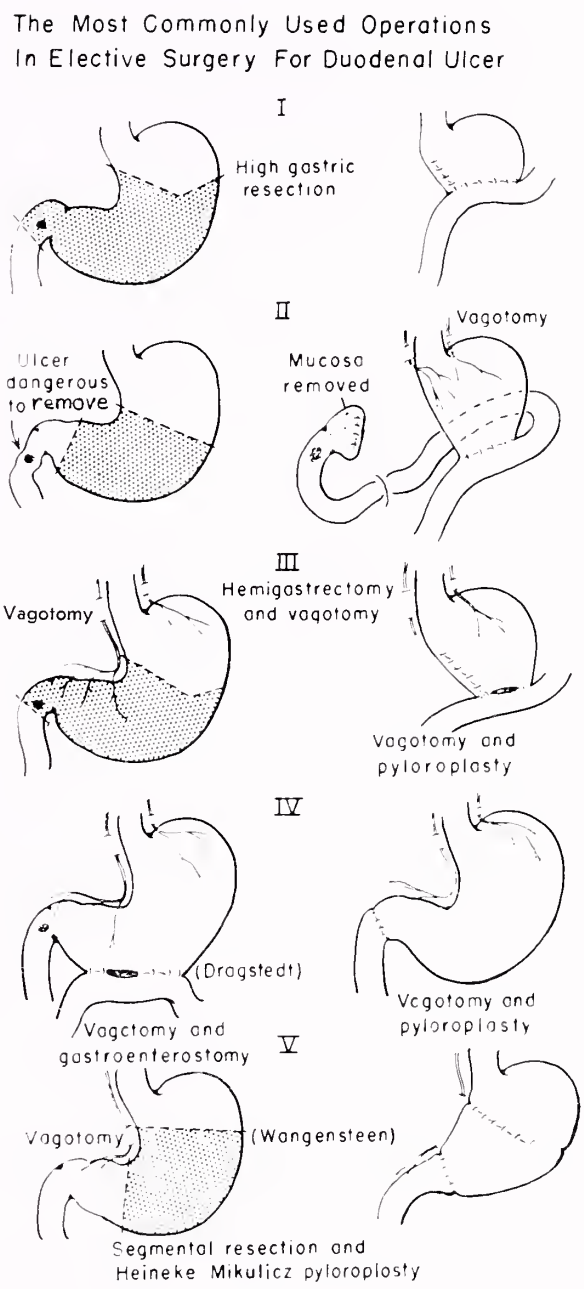


FIG. 1.

well pleased for the moment, at least, with hemigastrectomy and bilateral vagotomy.

Wangensteen and co-workers[2] seem satisfied with segmental resection of the stomach plus a pyloroplasty. They state: "In this operation the body of the stomach is excised and an anastomosis is performed between the antrum and the fundus. This operation is second only to total gastrectomy or esophagoantrostomy in extent of parietal cell resection. However, it differs from both these

[2] Wangensteen, O. H., Thal, A. P., and Perry, J. F.: The physiologic effects of various types of gastrectomy on gastric acid production with special reference to the function of the denervated gastric antrum. Surgery 41:576 (Apr.) 1957.

procedures in that about 10 per cent of the parietal cell mass is retained and also the food pouch is considerably larger, although now composed of the fundus of the stomach." They point out that since the lesser curvature of the stomach and its attendant vagal branches to the antrum and pylorus are included in the resection, it is necessary to perform a pyloroplasty to facilitate emptying of the gastric pouch.

The multiplicity of operations being used in the treatment of duodenal ulcers emphasizes the fact that unsatisfactory results must still be encountered regardless of the method used. Reference to Fig. 1 illustrates the more commonly used operative procedures at the moment in the surgical treatment of duodenal ulcers.

Surgical Treatment of Gastric Ulcers

When it comes to the surgical treatment of supposedly benign gastric ulcers, gastric resection is universally agreed upon as the operation of choice. This operation must be giving satisfaction because no one suggests doing anything else.

Very exceptionally the ulcer will be found to lie in close proximity to the esophagus and in this location there are some differences of opinion as to how it should be handled. Most ulcers that appear to lie alongside the esophagus from roentgenological examination are found at the time of surgery, after they have been properly mobilized, to be farther away than was expected, and can be resected without the esophagus' being encroached upon.

It is generally conceded, I believe, that if the ulcer cannot be resected, one should determine whether it is benign or malignant by microscopic examination of biopsies of its edges. If it is shown to be benign, the majority favor a high gastric resection, and if malignant, total gastrectomy.

Some surgeons, as reported by Welch and Burke[3] at the Massachusetts General Hospital, have had good results following proximal resection of the stomach with the ulcer. They state: "Proximal gastrectomy has been employed in the Massachusetts General Hospital for 15 juxtaesophageal ulcers. In an evaluation of this operation, Sweet in 1955 found that the postoperative results in 11 cases done at that time were excellent in the 10 who survived operation. This operation, however, should be combined with a pyloroplasty or gastroenterostomy, since the concomitant bilateral vagotomy may lead to gastric stasis and to recurrent gastric ulcer as noted by Smith, Moulder, and Adams. It must be admitted that other institutions have not been so favorably impressed with proximal gastrectomy. Some of these poor results may be due to unrelieved gastric stasis." In our own experience we have not used proximal resection of the stomach and neither have we found it necessary to do a total gastrectomy for a benign gastric ulcer.

When gastric resection for benign gastric ulcer is done, the ulcer can usually be removed without sacrificing an undue amount of the stomach, since most such ulcers lie in the mid- or distal portion of this organ. I do not believe that more than 50 or 60 per cent of the stomach should usually be removed. One very seldom sees a recurrent ulcer following a conservative resection for this condition, in contradistinction to a conservative resection for duodenal ulcer.

Since one can never be sure that an ulcer of the stomach is benign or malignant until a thorough microscopic examination of the ulcer has been made, the question always arises as to how extensive a resection should be carried out. Some have maintained that the operation should be as complete as one would do when the ulcer is known to be malignant. To me this seems too radical an approach. In the first place, clinically-appearing benign gastric ulcers will be benign in about 90 per cent of cases; if the ulcer is malignant and metastases have occurred to any extent, the chance of five-year survival is very small regardless of how radical the resection. Extensive removal of the stomach predisposes to disturbing postoperative symptoms, and the more radical the resection, the higher the operative mortality and postoperative morbidity. Therefore, I believe a margin of approximately five cm of stomach should be removed proximal to the ulcer, along with the lymph nodes in the gastrocolic mesentery and the gastrohepatic mesentery, especially those adjacent to the ulcer and including those in the region of the lower end of the esophagus. Frozen section study of removed regional lymph nodes, and opening the stomach and biopsying the wall of the ulcer, may be of value in deciding how radical an operation should be performed. If such examinations are negative, they do not rule out the possibility that subsequent more detailed examination may reveal malignancy.

Complications and Mortality

In any large series of cases, postoperative complications and surgical mortality are usually higher following gastric resection for duodenal ulcer than after resection for gastric ulcer. For the most part, this is due to difficulties associated with the handling of the duodenal stump. As Dr. Lahey frequently said: "Surgery for duodenal ulcer is largely surgery of the duodenum."

Wangensteen, O. H.: A critique of operations for peptic ulcer. Postgrad. Med. 23:466 (May) 1958.

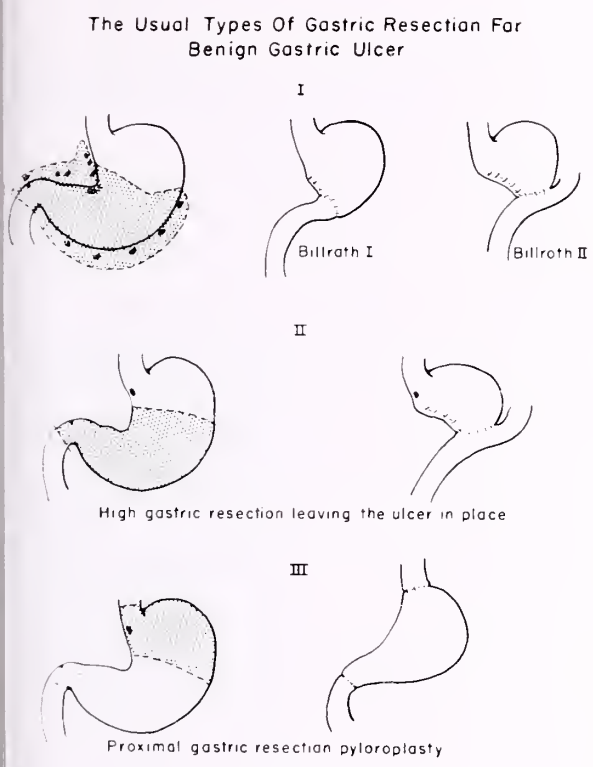


FIG. 2.

Attempts to invert a badly scarred duodenum, or efforts to remove an ulcer that might better be left in place, may result in duodenal leak or injury to the common bile duct or pancreatic ducts. Extensive dissection around the head of the pancreas may stir up an acute pancreatitis or allow escape of pancreatic enzymes that may cause subsequent complications. When satisfactory closure of the duodenum seems questionable, it is always advisable to drain this area.

It is good judgment, I believe, to leave the ulcer in place and do an exclusion operation if its removal appears difficult. Under such circumstances, it is mandatory to remove all the gastric mucosa of the remaining pyloric stump for reasons that have been previously discussed. Some surgeons maintain that they are always able to remove duodenal ulcers, but the vast majority admit they are not so adept and prefer to leave the ulcer in place under certain circumstances. Most surgeons, including myself, have no hesitancy in leaving the ulcer if its removal appears to be difficult and likely to result in complications. It is desirable when possible, however, to remove such ulcers when there is a history of previous severe hemorrhage.

It has been many observers' experience that the mortality following perforation of a gastric ulcer is higher than that following perforation of a duodenal ulcer. It has been supposed that this is so because the perforation of gastric ulcers is usually larger, and because the gastric content is usually less acid and therefore less likely to be sterile, in patients with gastric ulcer than in patients with duodenal ulcer. Hemorrhage from gastric ulcers is usually also more severe, due, it is thought, to the eroded vessel's being larger; and since most of the ulcers occur in an older age group than duodenal ulcers, the vessel wall is usually less contractile. Fig. 2 illustrates the accepted surgical method[3] used in the treatment of gastric ulcers.

Basis of Observations

These observations on the surgical treatment of duodenal ulcers and benign gastric ulcers are based on 782 such ulcers coming to surgery. Four hundred ten of the ulcers were duodenal and 371 were gastric.

There were 10 postoperative deaths following surgery for duodenal ulcer; four of these fell into the elective group which included a gastrojejunocolic fistula operated upon in 1936, before the use of antibiotics, and another with pyloric obstruction with the history of recurrent cardiac decompensation. The other six deaths followed surgical emergencies: two for perforation and four for severe hemorrhage not responding to conservative measures. One of the patients with perforation refused surgery for 48 hours and died of generalized peritonitis in the pre-antibiotic period. One of the cases of hemorrhage resulted from a stomal ulcer following a limited gastric resection for duodenal ulcer. The patient was operated upon on an adjacent island and had become exsanguinated before resection was attempted. Another case of hemorrhage was found at operation to be actively bleeding from both a duodenal and a gastric ulcer, and since it could not be determined which of these was responsible for the death, it is listed under each category.

Surgery for all types of benign gastric ulcer resulted in six deaths. Two of these followed elective gastric resection; two followed closure of a perforation; and two followed resection for severe hemorrhage. One of the cases of perforation occurred in a woman who had been under the influence of alcohol for several days; hence, the time of onset could not be determined. The other was in an individual with combined hemorrhage and perforation of several days' duration. One of these cases occurred in 1942, the other in 1943, both before antibiotic therapy had become available. One of the cases, as mentioned, bled from both gastric and duodenal ulcer.

[3] Welch, C. E., and Burke, J. F.: An appraisal of the treatment of gastric ulcers. Surgery 44:943 (Nov.) 1958.

Preferred Procedures

My own preference at the present time for the elective surgical treatment of duodenal ulcers (subject to change with increasing experience) is hemigastrectomy and vagotomy, removing the ulcer or leaving it in place as local conditions seem to indicate.

When perforated duodenal ulcers with limited peritoneal soiling are encountered and the patient seems a suitable risk, gastric resection, I believe, is the procedure of choice; otherwise, simple closure. We have had a very limited experience with the use of nasogastric suction, intravenous fluids and antibiotics, in the treatment of gastroduodenal perforations. I continue to be skeptical of the safety of this method of approach to the problem and would advise its use only under exceptional circumstances: namely, a poor surgical risk, or where facilities for surgical intervention are inadequate. Further experience by others may change this point of view.

Severely bleeding duodenal ulcers in my experience should have a short period of conservative therapy with the liberal use of blood. If not quickly responding satisfactorily, they should, in my opinion, be subjected to surgery. The time to discontinue conservatism in favor of surgical intervention is not easy to define. However, it should be remembered that most surgical deaths in everyone's experience in this condition occur when attempting to salvage individuals who have been treated too long conservatively.

Our experience with ulcerating lesions of the stomach lead me to conclude that they should all be resected, for the reasons previously stated. This includes not only the elective operations, but those for hemorrhage and perforation if this seems at all justifiable.

Total gastrectomy for a benign lesion is very rarely advisable. It leaves most people a gastric cripple and most benign lesions can be treated more satisfactorily by less radical measures.

Summary

Benign gastric and duodenal ulcers are dissimilar in many respects, the most important being as follows:

1. While both are acknowledged to be the result of the action of hydrochloric acid, the stimulating factor producing hyperacidity differs. In duodenal ulcer, the stimulus is of cephalic origin acting on the vagus nerves. In gastric ulcer, the stimulus results from food acting on the antral mucosa giving rise to a hormone, gastrin, which acts through the blood stream to stimulate the gastric glands that produce hydrochloric acid.

2. Duodenal ulcers should initially be treated medically, and most of them respond satisfactorily to this method of therapy. Operation in duodenal ulcer is only indicated for complications; namely, hemorrhage, perforation, pyloric obstruction, and intractability. The association of malignancy is not to be feared.

3. All ulcerating lesions of the stomach are surgical problems from the moment of diagnosis because they respond poorly to medical treatment; the possibility of malignancy can never be ruled out except by microscopic examination of the ulcer; and gastric resection for benign gastric ulcer is a very safe and a very satisfactory operation. Operations for gastric ulcer are safer and more satisfactory than for duodenal ulcers.

Summario in interlingua

Le termino "ulcere peptic" es confundente e deberea esser discartate proque illo designa duo totalmente differente typos de ulcere. Ulceres duodenal es causate per hyperaciditate neurogene (vagotonic), e lor tractamento es medical. Il es extrememente rar que illos deveni maligne. Ulceres gastric es inducite per hyperaciditate de causation local. Le tractamento medical de illos es relativemente inefficace. Illos non pote esser distinguite per medios clinic o radiologic ab formas precoce de cancere gastric. Il es multo plus facile resectionar los que tener los sub observation. Illos deberea esser tractate per gastrectomia partial si tosto que le diagnose es establite.

Osmosis into the jejunum seems the most likely cause of the dumping syndrome—but it is still mysterious

The Postgastrectomy "Dumping" Syndrome

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DEFINITIVE SURGERY in the treatment of peptic ulcer has become fairly well standardized during the past few years. The waves of enthusiasm for gastroenterostomy with or without vagotomy are undulating less vehemently, and subtotal gastric resection appears at present to offer the greatest hope to most sufferers in need of surgical treatment. Each technical variation has its advocates as to the size of the gastric remnant, the method of reconstruction of the alimentary tract, and the question of severing the vagi. The mortality from these procedures has reached a respectable minimum in competent hands; a certain degree of morbidity persists, however, and among the more distressing complications is a combination of symptoms referred to as the "dumping" syndrome.



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Symptoms Variable

Occurring in the early postprandial period, symptoms may consist of any combination of the following complaints: a sensation of fullness, tightness in the epigastrium, palpitation, nausea, weakness, sweating, dizziness, or even collapse.[1] Symptoms vary in intensity in different individuals, and may occur after all meals, or only after certain ones. They are usually ameliorated by assuming a supine position.

Etiology Speculative

Speculation as to the factors involved in the production of this syndrome and to methods of prevention and treatment has been the subject of countless discussions in the literature.[2] Though it is called the "postgastrectomy" syndrome, the symptom complex can also occur after vagotomy or gastroenterostomy, or even in individuals who have had no abdominal surgery.[3]

As is true of so many medical problems, the diversity of explanations precludes the probability that any one of the theories is applicable in all cases. The majority of explanations may be classified into five categories.

Mechanical Hypotheses

At the height of popularity of gastroenterostomy in the treatment of peptic ulcer, great stress was laid upon the location of the stoma in relation to the cardiac orifice. "Dumping" symptoms were thought to occur as a result of the food bolus' dropping directly from the cardiac orifice through the stoma. Some surgeons also stressed the importance of the size of the stoma, feeling that too small an opening would become obstructed easily, but that too large a stoma encouraged "dumping" symptoms.

In more recent years, since subtotal resection has become popular, the question of the size of the stoma, and to a lesser extent its location, has again been raised as a source of the "dumping" syndrome.

Schoemaker[4] of the Netherlands stresses the absence of "dumping" symptoms in 129 cases in which he used his own modification of the Billroth I operation.

Advocates of the Hofmeister-Finsterer procedure believe that the smaller stoma reduces the incidence of "dumping" symptoms below that obtained by the Reichel-Polya technique.

Hinton,[5] on the other hand, reports 230 consecutive resections, using an antiperistaltic, antecolic, short-loop Polya anastomosis, with only one case of the "dumping" syndrome. When he added vagotomy as a supplementary procedure to this technique, in 62 cases, he noted 15 patients with "dumping" symptoms—an incidence of 24 per cent. Five of these cases were listed as partially disabled by the syndrome. He felt that vagotomy was responsible for the complaints.

In addition to the size of the stoma and the type of anastomosis, some surgeons have stressed

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[1] Muir, A.: Postgastrectomy syndromes, Brit. Jour. Surg. 37:165 (Oct.) 1949.

[2] Bockus, H. L.: Recent advances in the treatment in the field of gastroenterology, J.A.M.A. 136:293 (Jan. 31) 1948.

[3] Alvarez, W. C.: The dumping syndrome: what makes it and how to avoid it, Gastroenterology 13:212 (Sept.) 1949.

[4] Schoemaker, C. A.: Partial gastrectomy in the war years, Surgery, Gynecology & Obstetrics 88:447 (Apr.) 1949.

[5] Hinton, J. W.: The evaluation of end results in physiologic versus pathologic operative procedures for chronic duodenal ulcer during the past two decades, Ann. Surg. 132:641 (Oct.) 1950.

the relative positions of the proximal and distal loops in relation to gravity as a possible explanation for "dumping" symptoms. More recently, Capper & Butler[6] have laid great stress on the supporting mechanism of the gastric remnant, and suggest anchoring it to the stump of the left gastric artery and gastrohepatic omentum.

In general, a high resection is more likely to be followed by "dumping" than is a more conservative procedure.[7] Total gastrectomy almost always results in postprandial complaints of a most distressing nature, while more conservative procedures done for distally located benign gastric ulcers generally cause little alteration in physiology. A resection high enough to produce the degree of hypoacidity necessary to control duodenal ulceration unfortunately also may produce "dumping" complaints. The recently advocated 50 per cent resection coupled with complete vagotomy is reputed to yield more favorable results. No long term follow-up of a large series has yet been reported.

Hypoglycemic and Hyperglycemic Hypotheses

It has been noted by various observers that gastrectomized patients and patients with gastroenterostomies exhibit abnormal sugar tolerance curves, with a diphasic response.[8] The diphasic response consists of an early hyperglycemia, usually without glycosuria, followed by a rather rapid fall to levels below the average. "Dumping" symptoms have been attributed to so-called "hyperglycemic shock," occurring immediately after meals.[10] Hypoglycemia has been shown to produce symptoms later in the postprandial period, but these differ from the typical "dumping" complaints.[11]

Jejunal or Gastric Irritation Hypotheses

Gray, Meyers, and Dockerty[13] made gastroscopic observations in all postgastrectomy cases with symptoms severe enough to warrant the examination. They observed gastroscopic evidence of gastritis, jejunitis, or both, in all cases, and speculated as to its importance in explaining the symptomatology. They further reviewed the pathological specimens removed from these patients and noted a high incidence of gastritis diagnosed histologically. They felt that such a diagnosis at the time of surgery carries rather ominous prognostic significance, and warrants prolonged dietary and medical management of the condition postoperatively.

Steinberg[14] states that the regurgitation of alkaline duodenal contents into an empty stomach may cause irritation and inflammation of the gastric mucosa. He first performs a side-to-side anastomosis in the loop of the jejunum brought up retrocolically, then anastomoses this sac to the transected gastric remnant. He states that this arrangement prevents the entrance of bile and pancreatic juice into the gastric remnant, and thus avoids many of the undesirable side effects of gastrojejunostomy.

Jejunal Distention by Osmosis

The experimental work of Machella of Pennsylvania[15] in 1949 laid the groundwork for a rational approach to the problem. He intubated the jejunum in a series of gastrectomized patients with "dumping" symptoms and a number of normal individuals as controls. By introducing hypertonic solutions of sugar into the jejunum, he could reproduce the familiar symptom complex. Further, he showed that blood sugar levels do not affect the train of events, since hypertonic solutions of sodium sulfate and casein hydrolysate gave similar results.

Following the intrajejunal instillation of hypertonic glucose, "dumping" symptoms can be demonstrated before hyperglycemia develops. Hyperglycemia induced by the intravenous administration of glucose fails to produce "dumping" symptoms. He concludes that in the early postprandial period, "dumping" symptoms are due to distention of the jejunum incident to the outpouring of fluid by the jejunal wall in an attempt to dilute hypertonic food material passed along by the nonretentive stomach, rather than to the mechanical presence of the ingested food per se.

The symptoms are not caused by hypoglycemia or hyperglycemia, though hyperglycemia may be present during the period of symptoms if the particular hypertonic solution responsible for their production happens to be a sugar solution such as sucrose or glucose.

Other experiments showed that balloon distention of the jejunum can reproduce "dumping" symptoms both in gastrectomized patients and in normal control subjects with intact stomachs. The

[6] Ferguson, L. K.: The dumping syndrome: a review of the pathologic physiology of dumping, Surg. Clin. N. Amer. 35:1693 (Dec.) 1955.

[7] Ross, J. R.: Dumping syndrome and other postoperative symptoms following partial and total gastrectomy, Surg. Clin. N. Amer. 35:703 (June) 1955.

[8] Langeron, L.: Manifestations hypoglycémiques chez les gastrectomies, Lille Chirurgical 4:187 (July-Aug.) 1949. Glaessner.[9]

[9] Glaessner, C. L.: Hyperglycemic shock, Rev. Gastroenterology 7:528 (Nov.-Dec.) 1940.

[10] Adlersberg, D., and Hammerschlag, E.: The postgastrectomy syndrome, Surgery 21:720 (May) 1947.

[11] Jefferson, N. C., Phillips, C. W., Levine, R., and Necheles, H.: Postgastrectomy and postvagotomy syndrome, Jour. Applied Physiol. 2:469 (Feb.) 1950. Culver.[12]

[12] Culver, P. J.: The dumping syndrome, Med. Clin. N. Amer. 3:1321 (Sept.) 1949.

[13] Gray, H. K., Meyers, W. C., and Dockerty, M. B.: Postgastrectomy gastritis, Surg. Clin. N. Amer. 28:965 (Aug.) 1948.

[14] Steinberg, M. E.: A double jejunal lumen gastrojejunal anastomosis: pantaloons anastomosis, S. G. & O. 88:453 (Apr.) 1949.

[15] Machella, T. E.: The mechanism of the postgastrectomy "dumping" syndrome, Ann. Surg. 130:145 (Aug.) 1949. Bockus.[16]

severity of the symptoms is directly proportional to the degree of the distention.

Machella states that the mechanical bulk of the ingested meal alone is not sufficient to produce "dumping" symptoms, since symptoms do not follow all meals. Ingredients producing high osmotic pressure must be present in the meal. These are usually sugars, but may be salt or protein products.

Furthermore, sufficient fluid must be ingested during a meal to dissolve the ingredients possessing osmotic properties, and yet yield a hypertonic solution sufficient to draw additional fluid from the blood stream into the gut. The omission of fluids from the meals of several of the patients resulted in a failure of the symptoms to develop.

Roberts and Farr, using Machella's technique of intrajejunal hypertonic glucose, demonstrated a "sharp drop in plasma volume of 300 to 750 cc, within 20 to 30 minutes, concurrent with the onset of the "dumping" symptoms. Constant but nonspecific electrocardiographic changes consistent with myocardial ischemia also occurred, and returned to normal with the disappearance of the "dumping" symptoms.[16]

Psychogenic and Neurogenic Hypotheses

It has been the general observation that the nervous, unstable individual is the one most likely to develop the syndrome after surgery. Furthermore, Alvarez reports a patient on whom no abdominal surgery had been performed, who nevertheless complained of typical "dumping" symptoms in the early postprandial period.

Prevention and Treatment

In view of the numerous theories described pertaining to the etiology of the "dumping" syndrome, it is obvious that as many approaches to treatment exist. Although certain experiments have contributed a great deal to the understanding of this problem, unfortunately not all patients who suffer from the symptom complex are relieved by the methods proposed for prevention and treatment.

Certainly, there are some suggestions which seem to have definite merit in a great number of cases. These include the limitation of fluids at meal time with ingestion between meals at a time when the stomach has emptied itself of the ingredients containing osmotic properties.[18] I have used this regimen prophylactically in my gastrectomy patients, with gratifying results. It has also been used to advantage in the treatment of a few patients with well established "dumping" symptoms. Again, unfortunately, in some of the worst cases of long standing, this regimen has been of no avail.

The elimination of certain foods known to possess high osmotic properties, such as candy, sugar, sweet pastries, carbonated beverages, etc., has resulted in the amelioration of symptoms in certain cases, but again, not in all cases. Five or six small meals daily, high in protein content, moderately high in fat, and low in carbohydrates have produced weight gain and control of symptoms.[19]

It is indeed questionable what part the use of various types of anastomoses, such as the Hofmeister-Finsterer with its smaller stoma or the Schoemaker with re-establishment of gastroduodenal continuity, plays in the prevention of "dumping" symptoms. "Dumping" symptoms have been reported following all of these procedures, and following gastroenterostomy alone.

Capper and Butler have reported good results in eight of nine cases whom they re-operated upon and supported the lesser curvature angle and afferent loop of the anastomoses by sutures to the tissues in the region of the left gastric artery.

Of various drugs used, atropine and atropine-like preparations in sufficient dosage seem to have a beneficial effect in some cases. The mechanism is not too well understood, but it has been stated that atropine lessens intestinal tone, diminishes muscular contractions, and as a result decreases intestinal motility. The mechanism is apparently not mediated through branches of the vagus nerves, since vagotomy has been repeatedly shown not to influence the development of symptoms. Small doses of codein orally before meals have been of help in a few difficult cases. Presumably decreased intestinal motility is again responsible. Possibly a yet-to-be described drug which stabilizes the vasomotor system may be of help in the future, perhaps even by preventing peptic ulcer.

Summario in interlingua

Le syndrome del dumping es un frequente e vexante complication del gastrectomia. Illo non es prevenite per le addition de vagotomia. De facto, illo pote esser inducite per un tal. Alte resectiones es plus frequentemente responsabile pro le syndrome que basse resectiones. Alterationes in le sucro del sanguine non es responsabile pro illo. Distension jejunal pare representar un plausibile explication etiologic. Iste distension es causate in parte per osmose a in le passage del jejuno. Il existe non ancora un completemente satisfacente methodo pro le prevention del syndrome del dumping.

[16] Bockus, H. L.: Postgraduate gastroenterology, Saunders & Co. 1950. Randall.[17]

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A physician reports his experience with hypnosis as a practical office procedure

The Use of Hypnosis in Medicine

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SINCE the teaching of hypnosis in medical schools was given official sanction by the British Medical Association[1] in 1955 and its use in medicine was recognized by the American Medical Association[2] in 1958, considerable interest in the field has been stimulated. The opinion that hypnosis has great potentialities for benefit medically has become stronger with its wider usage. There is hardly any specialty in medicine which could not be benefited by the intelligent use of hypnosis.

The following cases represent a variety of conditions in which hypnosis was used. The efficacy of the method, it is hoped, will stimulate more use of hypnosis among physicians.

Case Reports

CASE 1. *Warts.* A 30-year-old woman was referred on January 31, 1957, by a dermatologist because of warts of one and one-half year's duration. She had received injections, light treatments, and ointments over the previous six months without benefit. On physical examination numerous light tan colored, smooth, slightly raised warts of varying size, 2 to 5 mm in diameter, were noted over both cheeks and slightly over the forehead and sides of the neck.

The statement was made to the patient that, in my experience, I had noted that worry, nervous tension, and strain frequently were associated with the type of warts she had. I questioned whether or not this might apply to her. With an expression of relief spreading over her face, she remarked, "Oh, I thought of that for a long time, but I wasn't sure." Then she poured forth her story of having married a "local boy" while he was in service in the East. Upon returning to Honolulu to live, he began to show interest in other women, and they were divorced four years later. Since then, she had worked as a salesgirl to support herself. Her mother had died in Hong Kong a year ago. Two sisters were married. Her local circle of friends had been dropped recently because she had heard some of the women in the group remarking about the unsightly appearance of her face. She had quit her job and was making her livelihood by babysitting in order to avoid the public. She was tearful and despondent.

She responded well to hypnosis. In the first session, she was assured that the strain of her personal problems was definitely related to the warts and the suggestion was given that as she acquired an understanding of their relationships, the warts would disappear within two weeks. This was repeated the next day and three days later. She was seen eleven days after her initial visit. Her face and neck were clear. One month later she had taken a clerical job and two years later she was still free from warts.

CASE 2. *Asthma.* A 32-year-old woman was referred by her physician July 6, 1957, because of asthma. Her first asthmatic episode occurred in December, 1956, and was severe enough to warrant hospitalization. Following this, she had many attacks occurring in the early morning hours for which she received adrenalin by injection, antihistamines, and antibiotics. She was again hospitalized on two occasions for one week when her attacks were accompanied with severe vomiting and dyspnea. Symptoms cleared up in the hospital, but audible wheezing would recur soon after she returned home. An allergist had recommended that the family move from Wahiawa. After settling in Aiea, the patient was free from wheezing for one week, then she reverted to frequent attacks.

In the first session of hypnosis, the patient seemed to be responding well, until in an attempt to deepen her trance, the suggestion was given that her arms were becoming too heavy to lift. She carried out the suggestion, but spontaneously opened her eyes, breaking her trance. When asked why, she answered that she had witnessed a person being hypnotized, who, when stuck with a pin, cried, "Ouch!" She had visions that something similar would be done to her. She was assured that nothing would be done to hurt her. In the next session, no challenges were attempted and the patient was given the suggestions that her bronchial tubes would relax and stay relaxed as I pressed on both sides of her sternum, that she would sleep well and have good appetite. She improved markedly.

[1] Medical use of hypnotism, British Med. J. Supp. 1:190 (Apr. 23) 1955.
[2] Medical use of hypnosis, J.A.M.A. 168:186 (Sept. 13) 1958.

However, several nights later she had another asthmatic episode which prevented her from sleeping. Arrangements were made to meet her the next morning, on a Sunday, in the outpatient clinic at one of our hospitals. Here, during an hour's discussion of tension factors in her life, she related that she had married an only son of a local Japanese family. She was a "war bride," having met her husband while he was stationed in Japan. Living with her in-laws, she was constantly being criticized for not doing things as Japanese women in Japan were supposed to do them. She was feeling resentful toward her in-laws and guilty in the recognition of these feelings. There was also in the home the husband's elderly grandmother whose routine supervision was one of the patient's duties. The patient was under considerable apprehension that the old woman would injure herself during gardening activities and bring the wrath of her in-laws upon the patient.

She was assured that her feelings were understandable and natural and that she could develop a tolerance to the attitudes of her in-laws, so that they would not upset her. Then, under hypnosis, suggestions were again given that her bronchial tubes would stay relaxed and secretions which caused her to cough in the early morning hours would decrease; that as she understood the relationship between her relatives, tension, and her symptoms she would no longer have asthma. She improved over the next two weeks to become entirely free from asthma.

CASE 3. *Asthma in Childhood.* A nine-year-old boy was referred by his pediatrician on December 30, 1958, because of asthma. Episodes of asthma had started during infancy and had continued with increasing frequency; he was now having attacks "every few days." On questioning the mother concerning the circumstances which precipitated attacks, she replied, "When he catches cold, when he runs, when he gets excited, when he gets caught in the rain." He was one of four siblings.

The patient accepted hypnosis very well. When in a trance he was asked, "What brings on an attack?" He answered, "Running." He was offered the suggestions that his parents loved him; that his chest and bronchial tubes would stay relaxed, so the air he breathed could go in and out smoothly; that he would be able to run and play like the rest of his friends without wheezing; that his appetite would increase and his body would use well the food he ate; that he would get stronger, so whenever he did catch a "cold," he would get well just like any healthy person without wheezing.

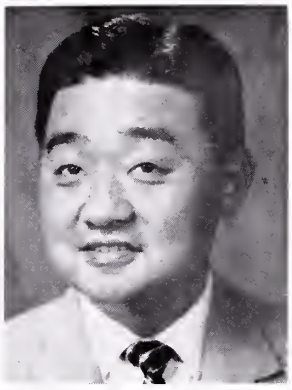
The negative influences of handling the patient in a manner which was too protective, restrictive, and solicitous were discussed with the mother. She was assured that running, perspiring, and getting caught in the rain were natural events in children's lives and should cause no harm to the patient. She agreed to restrict herself in her handling of the patient and to show him genuine affection. She was also advised to discuss the matter with her husband and enlist his cooperation.

The patient was seen twice at one-week intervals, then every two weeks for four times. His asthma had cleared up and he had had two "colds" without wheezing. He gained over two pounds and was playing, asymptomatically, as actively as his friends.

CASE 4. *Migraine.* A 36-year-old woman was seen September 16, 1957, because of migraine headaches. The headaches had started about five years previously and had increased in severity and frequency. In the past year she had had as many as three migraine attacks in a month, but usually once a month, lasting two or three days and of such severity that she could not go to her job as a secretary. She had taken ergotamine tartrate at the onset of attacks with inconsistent relief.

Emotionally upsetting factors were present in her marriage to an immature, artistic husband who shared no responsibility in the raising of their only daughter. Divorce had been contemplated on several occasions, but had been dropped, purportedly for the child's sake.

The patient responded well to hypnosis. She was told that inasmuch as she understood the source of emotional upset, the solution would be relegated to her own conscience. However, she was assured that she could learn to abort migraine attacks by learning to relax herself. She was then taught self-hypnosis during several sessions. The suggestions were also given that immediately upon recognition of early symptoms of migraine, she would find a place to recline, place herself under hypnosis, and suggest that she would sleep for one or two hours, then awaken with a clear head, feeling rested and comfortable. This proved to be very effective. All suggestions were reinforced in three subsequent sessions. Since then the patient has been able to do her self-hypnosis, as needed, with good results.


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CASE 5. *Obesity.* A 49-year-old woman requested hypnosis for her overeating problem and was first seen March 20, 1958. She had become obese at 35 years of age and had dieted under standard medical routines many times. She had been able to lose weight, only to relapse after several months. Her eating habits consisted of seconds of dessert at lunch and supper; between meals she ate nuts, cheese, and crackers; cocktails before supper; and a snack before bedtime. She believed the source of her overeating lay in the stresses associated with her job. She weighed 205 pounds and her goal was to reduce to 160 pounds. She claimed she was familiar with the contents of a 1,000-calorie diet.

She was a good hypnotic subject. Suggestions were given that she would have the desire and determination to stay on a 1,000-calorie diet, she would be comfortable between meals without experiencing hunger pangs, and she would not need to take any medication. She was asked to keep a three-day diet record. These totaled 1,025, 1,095, and 1,245 calories respectively. In her third session, she was started on instructions in self-hypnosis. One month after her initial visit, she weighed 193 pounds and was performing self-hypnosis daily. She reported that on weekends she was eating 300 to 400 calories more than on week days. Suggestions were re-enforced with the addition of the suggestion that she would feel good about being in control of the dieting problem as she noted her weight decreasing.

On May 1, 1958, she weighed 189 pounds and reported that she was to attend a convention on the mainland in June. Suggestions were given that she could increase the intervals between self-hypnosis to four days and that she would be able to abide by her diet no matter what festivities she would be exposed to throughout her trip. She came in for her last visit August 29, 1958. She weighed 176 pounds, and had been continuing self-hypnosis weekly.

CASE 6. *Nausea and Vomiting in Pregnancy.* A 34-year-old woman physician was referred to me in January, 1959, by a psychiatrist because of excessive nausea and vomiting. She was in the fourth month of her third pregnancy. In the first two pregnancies she had to be hospitalized several times because of dehydration and electrolyte imbalances resulting from severe vomiting which continued for the duration of the pregnancy. She had consulted a psychiatrist because her nausea and vomiting were again severe and she was feeling weak and "run down." She could not carry her surgery schedule and was having difficulty in just seeing patients. The psychiatrist referred her to me because his use of hypnosis was restricted to psychiatric illnesses.

The patient was a receptive subject. She responded to suggestions of relaxation of her stomach, of enjoying food and feeling comfortable after eating. Because she felt worse when hunger was apparent, she was advised to take a small snack between meals. Immediate improvement was noted and after five visits she was taught to do self-hypnosis and was able to carry on a full practice schedule.

CASE 7. *Pain, post-hemorrhoidectomy.* A 40-year-old man requested the use of hypnosis for analgesia relative to a scheduled hemorrhoidectomy in November, 1958. He was first seen four days prior to admission to the hospital. He was receptive to hypnosis and was able to experience anesthesia of the right forearm which he was asked to test for himself by pinching first his left forearm, then the right. Then, this same response was suggested to be present after his hemorrhoidectomy in the area to be involved. He was next seen after admission to the hospital, the day before surgery and suggestions were reinforced. Surgery was performed with spinal anesthesia.

The postoperative period was devoid of pain relative to his bowel functions. However, unknowingly, the patient failed to urinate for about 12 hours postoperatively and developed mild bladder atony which returned to normal function in about four days. Had foresight been adequate, the urinary symptoms could have been averted by inclusion of normal urinary function in the suggestions given.

Discussion

These cases illustrate the wide applicability of hypnosis in medicine. The cases of asthma, migraine, and warts emphasize the importance of emotional factors in the genesis of symptoms of illness. It is recognized that removal of symptoms by suggestion alone, without working out the areas of emotional tension, would be using hypnosis only in an elementary degree. As the subject discusses areas of tension or worry in the hypnotic state, he often remarks after the trance that he had not realized that the problems discussed had been serving as sources of tension. Then, he adds how relieved he feels and notes that his original symptoms have improved or disappeared. Psychotherapy of a superficial nature apparently suffices to enable the subject to focus on tension areas in relation to his symptoms and allows him to resolve his anxieties without transferring them to new or different symptoms. Deeper investigation of psychiatric maladjustments seemed unnecessary in the cases described.

The value of incentive in promoting the success of hypnosis is illustrated in the case where analgesia was produced for the post-hemorrhoidectomy period. The patient had heard of the pain and suffering other persons had experienced after their operation. To spare himself a similar ordeal, he was willing to avail himself of hypnosis. Thus the incentive for effective acceptance of hypnosis, as described by Cheek,[3] was great, assuring its success.

Other conditions in which hypnosis has proved valuable in my experience include obstetrical labor and delivery, enuresis, arthritis, bursitis, cardiospasm, stuttering, and dental work. The results observed parallel those of Kroger and DeLee,[4] Michael,[6] Abramson, and Heron,[7] who have effectively used hypnosis for childbirth; Rosen,[8] Schneck,[9] LeCron, and Bordeaux,[10] who have reported benefit in speech difficulties; and Jarabak[11] and Marcuse,[12] who describe wide usage of hypnosis in dentistry.

Summary

The use of hypnosis in medicine has been officially recognized. Its practical applicability in many common ailments is illustrated. Simple symptom removal with hypnosis is discouraged and recognition of emotional factors in the production of symptoms is encouraged. Superficial psychotherapy with hypnosis seems adequate in successfully alleviating tensions and symptoms of illness.

Summario in interlingua

Es reportate exemplos del uso efficace del hypnose in le tractamento de verrucas, asthma, migraine, obesitate, emesis de pregnantia, e dolor postoperatori. Le autor ha trovate le uso del hypnose de valor, in plus, in parturition, enuresis, bursitis, arthritis, cardiospasmos, balbutiamento, e interventiones dental.

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How healthy are Oahu's school children?
Here's a close look at this important problem

Preliminary Report

School Health Services Evaluation Study

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THE School Health Program in the public schools of Hawaii is based upon the conviction that good health is essential to effective living and is an important goal of education, While the primary responsibility for the child's health remains with the parents, the school—through referrals and education—encourages, assists, and reinforces the efforts of the home.[2]



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Consistent with current trends to evaluate school health programs,[3] and in the absence of previous local studies, the School Health Services Evaluation Project was designed to evaluate the effectiveness of health services available in the elementary public schools. The study involved multiphasic examinations of a selected sample of elementary school children on Oahu with reference to their state of health, unmet health needs, and communication between home and school regarding health of the children. The evaluation was confined to health services,[4] one of the integral parts of the total School Health Program. Other components of the School Health Program not considered directly are health instruction, school environment, and physical education programs.

Participating Agencies

The study was sponsored by the Oahu Tuberculosis and Health Association in collaboration with the Department of Public Instruction, Department of Health, and Bureau of Sight Conservation.

The Oahu Tuberculosis and Health Association provided finances from locally contributed Christmas Seal funds, in accord with the National Tuberculosis Association's "Approved Principles for Programs of Voluntary Tuberculosis Associations."[5] Staff members of the above agencies who participated in the study did not receive project remuneration.

[1] Analyses and preparation of tables by Mrs. Jo Ann Zayno and Mrs. Dora Lee.

[2] School Health Policy, Revised, 1959.

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Baumgartner, L.: School health—yesterday and tomorrow, Am. J. Pub. H. 48:771 (June) 1958.
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[4] School Health Services include: (1) For all students—general observation by classroom teacher; Snellen eye examination; dental examination by dental hygienist; referral of cases with suspected health problems. (2) For selected students (as resources permit) follow-up by principal and health personnel; psychological testing; speech evaluation; audiometric testing, and screening otological clinics; social casework; follow-up with parents, and case conferences. (3) The Public Health Nurse serves as a consultant to school personnel on health matters, and provides follow-up on school health problems on request.

[5] Oermann, K.C.H., and Masonbrink, E.: Next steps for voluntary health agencies, J. School Health 29:240 (June) 1959.

TABLE 1.—*Names and Areas of Responsibility of Examination Team Members.*

1. Medical Director—Katherine J. Edgar, M.D., Bureau of Maternal and Child Health, Department of Health
2. Technical Director—Chew Hin Au, Oahu Tuberculosis and Health Association
3. Design, Methodology and Analysis—Robert A. Spicer, Ph.D., Division of Mental Health, Department of Health
4. Statistical Analyst—Jo Ann Zaynor
5. Coordinator—Dolores G. Wininger, Public Health Nurse
6. Health Education—Marie H. Sharp, Oahu TB & Health Association
7. General Physical Examinations—Donald F. B. Char, M.D.; Bernard J. B. Yim, M.D.
8. Dental Examinations—Masaichi Oishi, D.D.S.
9. Ophthalmological Examinations—Vernon K. S. Jim, M.D.
10. Vision Screening—Margaret S. Fujita, Bureau of Sight Conservation
11. Ear, Nose and Throat Examinations—Jen Fong Moo, M.D.
12. Speech and Hearing Examinations—Renee Powell, Bureaus of Maternal and Child Health and Crippled Children, Department of Health
13. Laboratory (hemoglobin and urine screening tests)—Jane Hanlon
14. Psychological Tests—Helen Weaver, M.A., Psychologist
15. Tuberculin Tests—Agnes V. Peterson, RN, Oahu Tuberculosis and Health Association
16. Parent Interviews—Helen Hong, M.A., Social Worker
17. IBM Data Processing—Tad Nakano, IBM Department, University of Hawaii
18. Volunteer Assistants—Mr. and Mrs. Alex J. Walsh, Mrs. Velma Powell

Objectives of the Study

The objectives of the study were:

1. To evaluate, within given limits, the current mental, emotional, and physical state of health of elementary school children on Oahu.
2. To evaluate effectiveness of school-home communication relative to school health services.
3. To determine the nature and extent of unmet health needs of elementary school children.

In addition to the above, the study was intended to furnish meaningful data to the cooperating agencies which would lead to the improvement and better coordination of services made available through the schools. It was hoped that the study would also provide a feasible pattern for future evaluations.

Methodology

Thirty-four fifth grade[6] sections from 31 schools[7] in rural and urban Oahu were selected in a prescribed random fashion to allow for reliable statistical evaluation of the findings. The sample consisted of 1,064 children (573 boys and 491 girls) from a total population of approximately 7,000 fifth grade students. Twenty-one other children in these 34 sections were not included in the study because they lacked the necessary parental consent.

All of the children were examined systematically at the rate of one class section per week beginning in September, 1957. Individual examinations were carried out at the schools involved. The examination team consisted of 15 professional workers (See Table 1).

To minimize bias, school personnel, children, and parents were not informed of their expected participation until just prior to the examination. Written consent forms from the parents were employed.

Just prior to examination day (E-Day),[8] the fifth grade section to be examined was announced, and the children were oriented by the Project Coordinator (Nurse) and Health Educator. Consent slips and urine specimen bottles were sent home with the children. Both were returned on E-Day. The psychologist advised the classroom teacher who administered the California Mental Maturity and California Achievement Tests, and the completed answer sheets were machine scored. The teacher was also advised by the psychologist with reference to making "rank order" evaluation of her students regarding classroom adjustment. These rankings were used as one of three basic criteria for making adjustment ratings by the psychologist. The other two criteria were scores obtained on an adjustment questionnaire filled out by the student, and discrepancies between California Mental Maturity and California Achievement Test scores.

On E-Day children were assigned identification numbers, given individual packets of precoded examination forms, and routed to examination stations. Tuberculin testing was done by a special team employed in another study project. Except for classroom administration of the California Mental Maturity and Achievement Tests and the tuberculin testing, all of the examinations of a fifth grade section were completed in one day.

One omission of importance should be mentioned. The examiners did not have the usual benefit of a medical history of the child. Some information was obtained from the school health record, and the Social Worker in some cases elicited history in the home *following the examination session* regarding conditions which were not apparent at the time of the examination. Such conditions were: allergy (especially asthma and hay fever), convulsive disorders, rheumatic heart disease (without evidence of murmur at the time of the examination), intermittent hernia, etc. The examiners found that the lack of contact with

[6] Fifth grade children were selected as the sample for evaluation of health of elementary school children for the following reasons: they had received four years of attention in the School Health Program; fifth graders have had required physical examinations on entrance to school and recommended examinations on entrance to fourth grade; this age group is considered to be in a relatively quiescent stage; screening tests for emotional disorders can be used at this age level. Mainland studies disclose minimal disparity between the health of fifth graders and that of other grade levels and they are therefore adequately representative of elementary school children.

[7] Aina Haina, Kapalama, Lincoln, Likelike, A. A. Scott, Pearl Harbor Kai, Halawa Kai, Palolo, Manoa, Pauoa, Wahiawa, August Ahrens, Thomas Jefferson, Kuhio, Kainalu, Kailua, Waimanalo, Kalihi, Kalihi-uka, Lanakila, Maemae, Waianae, Ewa, Hickam, Aliiolani, Laie, Waialae, Koko Head, Benjamin Parker, Liliuokalani, Kahuku

[8] Hereafter examination day will be referred to as E-Day.

TABLE 2.—*Classification System of Defects Used by All Examiners.*

Severity	*Status*
Not Remarkable	Correctible
Incomplete Diagnosis	Partially Correctible
Health and Adjustment Handicap	Not Correctible
Potential Handicap	Partially Corrected
Acute Condition	Corrected
Minor	

the parents imposed by the study was a definite drawback, but this was considered to be necessary by various advisors. Lack of knowledge of handicaps which might be elicited by a history made it difficult to classify these later as to degree.

Each examiner recorded his findings on a precoded IBM form. For each child adverse conditions were recorded and classified as to nature, degree of severity, and correctibility. It was necessary in each case for the examiner to make a professional judgment regarding classification and scaling as shown in Table 2. These scales were necessarily arbitrary but allowed for comparative evaluations of children on a common basis for all the different examinations.

Defects identified were summarized later in a letter by the Medical Director and sent to the physicians whose names were given on the consent slips. This was a plan agreed upon with the Honolulu County Medical Society. Where children received their medical care at military installations or from outpatient departments of hospitals the summaries were also forwarded to those facilities.

Throughout this paper, adverse condition or defect implies any one of four degrees of severity: Health and Adjustment Handicap, Potential Handicap, Acute Condition, or Incompletely Diagnosed. Within each special area of examination (e.g., vision, hearing, dental findings, etc.) conventionally acceptable operational definitions were employed. As each area is analyzed the operational rules will be described.

Minor conditions (these are not reported in the following tables) are defects judged by the examiners to be reportable, but which did not appear to interfere materially with the child's normal functioning or in his making an adequate school adjustment. "Not Remarkable" means complete absence of defect.

School Health Records (DPI Form 14 etc.) were microfilmed and pertinent data transferred to the Project records. The purpose of this procedure was to learn what defects had been previously known to the school, and if possible, what action had been taken. Following E-Day, the social worker visited each home and through personal interview determined what knowledge the parents had of the defects in question, where they had learned of the defects, and what action had been taken. If no action had been taken, she endeavored to learn why. Although the social worker had knowledge of the findings, she did not divulge them to the family (per agreement with the Honolulu County Medical Society). She also obtained demographic information and recorded it on precoded forms.

Findings

The remainder of this and subsequent reports will be devoted to descriptive analyses of data collected in the study. This paper deals with: (1) a summary of the general health of the children examined; (2) demographic data; (3) information on corrective action.

Later articles will describe specific areas of examination (i.e., vision, hearing, dental, etc.) in greater detail.

I. General Health of the Children Examined

Of the 1,064 Oahu fifth graders who were examined, 686 (64 per cent) were found to have health handicaps which were judged by the examiners to be more than "minor" in severity. Twelve per cent of the children had three or more defects. The mean number of conditions for the total sample of 1,064 was 1.2 conditions per child. The mean for the 686 students with conditions was 1.8 conditions per child. See Tables 3 through 6 for summary of defects identified and the occurrence of two or more defects in the same child.

The following tables show the distribution of the children by number and type of health handicaps discovered during the examination. None of these tables distinguish the defects which have

TABLE 3.—*Distribution of Students by Type of Health Handicap.*

TYPE OF DEFECT	NUMBER OF CHILDREN WITH DEFECT	PER CENT OF CHILDREN
Physical[9]	153	14
Laboratory	59	6
Dental	216	20
Visual	149	14
Ophthalmology	28	3
Hearing and Speech	106	10
Otology	140	13
I. Q.	52	5
Adjustment	218	20
Number of children with defects	686	64
Number of children with no defects or only minor	378	36
Total number of children	1,064	100

[9] Defects not included in the special categories (such as heart murmurs, scoliosis, adenitis.

already been corrected or were in treatment. For example, children were classified as having a visual handicap even though many of them were wearing corrective lenses.

Table 3 lists the number and percentage of children showing defects in the different areas of examination.

Table 4 shows the student distribution by number of defects present.

TABLE 4.—*Distribution of Students by Number of Defects per Child.*

NUMBER OF DEFECTS PER CHILD	NUMBER OF CHILDREN	PER CENT OF CHILDREN
0	378	35.5
1	374	35.2
2	180	16.9
3	68	6.4
4	41	3.9
5	9	0.8
6	8	0.8
7	4	0.4
8	2	0.2
TOTAL	1,064	100.0

A summary of the information in Tables 3 and 4 is presented in Table 5. This shows the types of conditions frequently associated with each other.

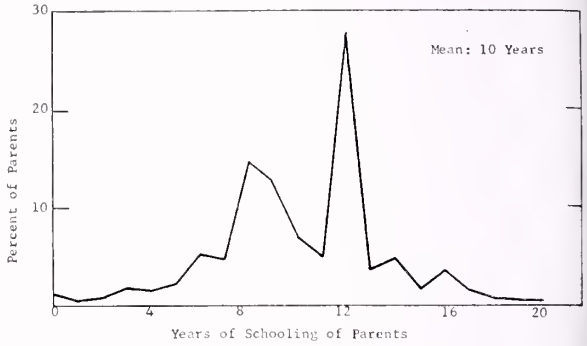
TABLE 5.—*Number and Types of Defects Frequently Occurring Together.*

TYPE OF EXAMINATION	NUMBER OF STUDENTS WITH DEFECT	KINDS OF DEFECTS WHICH APPEAR TO BE ASSOCIATED BY OCCURRENCE IN RATIO OF 1 IN EVERY 5 CASES[10]
Physical	153	.....
Laboratory	59	Adjustment
Dental	216	Adjustment
Visual	149	Adjustment
Ophthalmology	28	Visual, Adjustment, or Dental
Hearing and Speech	106	Otology, Adjustment, or Dental
Otology	140	Hearing, Adjustment, or Dental
I. Q.	52	Dental, Adjustment, or Physical
Adjustment	218	Dental

II. Social and Demographic Data

Ethnic Origin— In the random sample of children examined, ethnic groups were found in proportions consistent with census statistics. (Department of Health criteria were used in making the ethnic classifications). The sample is therefore assumed to be representative.

[10] For example, adjustment problems appeared to accompany all types of defects except "Physical."



GRAPH 1.—*Education of Parents.*

Education—The effectiveness of any health program depends on adequate communications between school and parents. All written health information or education in regard to the child should be geared to the educational level of the parents. The educational background of parents of the children of the study sample is shown in Graph 1. A conspicuous trend was observed which suggests that children of parents with higher education have fewer defects. It was found, too, that higher education levels of parents correlated with higher degree of corrective action taken. Parents with less than 8th grade education made up a larger number of the no-corrective action group.

Occupation—Table 7 shows distribution of the parents of the children by occupations. These data were classified on the basis of criteria given in the Dictionary of Occupational Titles. The person identified as head of the household is included in the following statistics. Defects identified in the study were not found to be correlated with this variable.

Income—Table 8 shows the income ranges of the families of the children examined, percentage

TABLE 6.—*Distribution of Children Examined and Total State Population, by Ethnic Groups.*

	PER CENT OF CHILDREN EXAMINED	PER CENT OF TOTAL POPULATION (1950 Census)
Japanese	33.7	38.6
Part Hawaiian	21.1	15.4
Caucasian	18.7	20.0
Filipino	9.2	12.6
Chinese	8.0	6.8
Hawaiian	0.6	2.5
Other	6.7	4.1
Unknown	2.0	0.0
	100.0	100.0

TABLE 7.—*Distribution of Students by Occupation of Breadwinner.*

OCCUPATION	NUMBER OF STUDENTS	PER CENT OF STUDENTS
Professional and Managerial	202	19.0
Clerical and Sales	121	11.4
Service Occupations		
Domestic	2	0.2
Personal	28	2.6
Protective	144	13.5
Building	20	1.9
Agriculture, Fishing, and Forestry	59	5.5
Skilled	247	23.2
Semiskilled	109	10.2
Unskilled	40	3.8
Unknown	92	8.6
	N = 1,064	100.0

TABLE 8.—*Distribution of Students and Working Mothers by Income.*

ANNUAL FAMILY INCOME PER STATEMENT OF WIFE/MOTHER	NUMBER OF STUDENTS	PERCENTAGE OF STUDENTS	NUMBER OF WORKING MOTHERS	PER CENT OF WORKING MOTHERS
DPW	17	1.6	0	0
$0–$1,499	11	1.0	3	0.7
$1,500–$2,999	104	9.8	31	7.0
$3,000–$4,499	267	25.1	78	17.7
$4,500–$5,999	301	28.3	130	29.5
$6,000 & Over	332	31.2	195	44.3
Unknown	32	3.0	3	0.7
	N = 1,064	100.0	N = 440 41.4% of 1,064	100.0

Median Incomes—$5,080.

(Median family income for Oahu is $5,744, according to a survey recently reported by the State Planning Commission—December, 1958.)

of students for various income brackets, and percentage of working mothers at the different income levels.

Forty-one and four tenths per cent of the mothers of the children examined were working at the time of the study. The children of working mothers did not appear to have a greater number of defects than the children of nonworking mothers.

Children from homes where income was less than $3,000 per year were likely to have a greater number of defects and less corrective action than average. The reverse condition was present for incomes in excess of $6,000.

Family Structure—The possibility that the size of the family might constitute a significant variable in health conditions was investigated. The distribution of family size by number of children is shown in the histogram in Graph 2. There is a distinct trend toward more defects and less corrective action as the family becomes larger than six members.

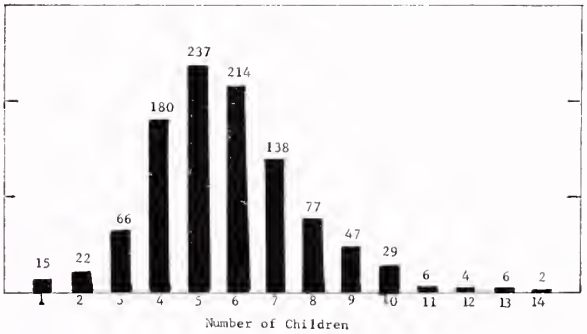
According to the data collected, 77 per cent of children lived with their own (natural) parents. The absence of one or both natural parents was associated with less corrective action and more defects than found in children living with both natural parents.

Maternal Attitudes—Measures were taken of the attitudes expressed and concern shown by mothers regarding the health and general welfare of their children. A five-point rating scale was utilized by the social worker for this purpose. She based her rating on a personal home interview with the mother.

The social worker reported that approximately 50 per cent of the mothers indicate a sustained active interest in their children's welfare. This suggests that one-half the mothers interviewed try to provide medical attention on a periodic basis and are alert to reports from the school and other sources concerning the children. Approximately 35 per cent of the mothers showed a similarly active interest but reported that work routines (in or outside the home), additional responsibilities, domestic problems, and the like tended to interfere with their consistent attention to the child's health and welfare. About 10 per cent of the mothers were noted as being overly anxious and overly concerned about their child's health. The remainder, who represent a small proportion, gave interview responses which might suggest a lack of genuine interest in the child's welfare.

The following conditions appear to be related to maternal attitudes:

1. More low I. Q. levels were found in children with "indifferent" mothers than any other group. The anxiously attentive and "indifferent" had children who showed significantly more defects than the average.



GRAPH 2.—*Distribution of Family Size (N-1044).*

TABLE 9.—*Parents in Home.*

Both natural parents in home		820	77.1%
Natural father in home		43	4.0
Mother missing	1		
Mother dead	3		
Mother divorced or separated	16		
Stepmother	21		
Mother unmarried	1		
Grandmother	1		
Natural mother in home		127	11.9
Father dead	19		
Father divorced or separated	32		
Stepfather	60		
Adoptive father	6		
Father working elsewhere	5		
Father unmarried	4		
Father not stated	1		
Both parents absent:			
Child living with:		53	5.0
Grandfather and grandmother	13		
One grandparent	5		
Uncle or aunt	8		
Other	4		
Adoptive parents	16		
Foster parents	7		
Unknown		21	2.0
	Total	1,064	100.0%

2. Visual defects occurred more frequently among the consistently concerned group than among the children from "indifferent" homes.
3. The anxiously attentive and "indifferent" mothers had children who showed a higher incidence of adjustment problems than did the average.
4. The average and the anxious parents were more likely to take corrective action than were the other mothers.

Summary

1. A representative sample (1,064) of Oahu fifth grade children were given individual screening examinations to determine health status.

2. School records and home interviews provided information regarding previous knowledge of defects and effectiveness of school-home communications regarding health problems.

3. Techniques for recording and scaling child health findings were developed.

4. Sixty-four per cent of the children were found to have defects which were considered "more than minor." Twelve per cent had three or more defects. (These percentages do not indicate whether or not corrective action had been taken).

5. Factors which tend to increase the number of conditions affecting a child are large families, absence of natural parents, low income, and either an indifferent or anxious attitude displayed by the mother.

6. Factors which contribute to the lack of corrective action are large families, absence of natural parents, low income, low education level of the parents, and the indifferent attitude of the mother.

Subsequent articles will report on: (1) vision screening and ophthalmological examinations; (2) audiometric and otological examinations; (3) speech evaluations; (4) dental examinations; (5) general physical examinations and laboratory screening tests; (6) intelligence, achievement, and adjustment. In each of these areas descriptive and numerical analyses will be given, with some implications for program planning to meet the needs of school children.

Acknowledgment

The following served as an Advisory Committee for the study:

Alfred M. Church, Ed.D., Deputy Superintendent, Department of Public Instruction, Chairman
Tate Robinson, Director of Health Education, Department of Public Instruction
Charles C. Macnamara, Executive Director, Oahu Tuberculosis and Health Association
Chew Hin Au, Oahu Tuberculosis and Health Association
John T. Kometani, M.D., Pediatrician
Douglas S. Yamamura, Associate Professor of Sociology, University of Hawaii
Joseph I. Bishop, Assistant Superintendent Oahu District, Department of Public Instruction
Ione Rathburn, Professor of Health Education, University of Hawaii
Katherine J. Edgar, M.D., Bureau of Maternal and Child Health, Department of Health

Summario in interlingua

Un selection representative de pueros e pueras del quinte anno scholar in le insula Oahu esseva cautemente testate e examinate pro defectos physic e mental o emotional. Le serie consisteva de 1.064 subjectos. Duo tertios habeva un o plure major defectos, incluse tales—per exemplo defective acuitate visual—que habeva jam essite corrigite. Dece-duo pro cento habeva tres o plure defectos. Constatationes associate con un multiplicitate de defectos esseva grande familia, absentia del parentes natural, basse ressources economic, e indifferentia o excessos de solicitude del parte del matre. Absentia de mesuras de correction esseva associate con grande familia, absentia del parentes natural, basse ressources economic, basse nivellos educational del parentes, e indifferential del matre.

The President's Page


Bauer

DR. NISHIGAYA

HAUOLI MAKAHIKI HOU!!

1960 brings on a new decade—and challenges in medicine. Many will be old, but others will be new, with the inevitable problems confronting us.

The decade just passed will seem relatively quiet compared with what is coming. The greatest problem medicine had to face was the impact of panel practice, with the misunderstandings and arguments over the Community Group Plan as offered by H.M.S.A. Though the threats of socialized medicine were ever present, they never fully materialized.

Today, we are confronted with the problem of Federally subsidized health insurance for all Federal employees (Public Law 86-382). In Hawaii, the only plans which would offer free choice of physician will be (1) Aetna insurance, offering hospitalized care only, and (2) H.M.S.A., in all probability, without any income ceiling clause (though a decision has not yet been made on this point). We may be damned if we don't accept this severe restriction on our fees—for if we don't, most of these patients will be cared for by a system of practice which the majority of the medical profession here opposes.

But we may equally be damned if we *do* accept it—because if we allow ourselves to be compelled to charge scaled-down fees for all these Federal patients, regardless of income, we may well find that we have to do the same for *all* patients. The next group of them will probably be Hawaii State employees—and after that, there will be others.

Committees from H.M.A. and the H.C.M.S. are diligently and conscientiously working out details most beneficial to the subscribers as well as the profession. Whatever the outcome, the profession in Hawaii can be proud of the efforts of these members who are expending thought, effort, and time to make workable something which has been created and tossed at us without counsel from the profession.

Many other important decisions will have to be made, but I am confident, as we look forward in this new decade, that the physicians in Hawaii possess the talents and the type of thinking which will enable us to cope with any and all situations.

T. Nishigaya, M.D.

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[EDITORIALS]

The Forand Bill–A Wrong Answer

The American Medical Association agrees with Representative Aime Forand of Rhode Island that a good many persons over 65—like a good many of those under 65—find the cost of illness burdensome. Nevertheless, his bill to correct this, H.R. 4700, was the only item of legislation before the first session of the 86th Congress which the A.M.A. opposed.

Their criticism of his bill was that it would protect the wrong individuals against the wrong things, and would do it the wrong way. In singling out OASI beneficiaries it would not cover all or even most of the needy, nor would it exclude many of the well-to-do or the already adequately insured. In protecting these persons against hospitalized illness it would create a strong inducement to seek unnecessary hospitalization in preference to office care, which is not only financially unsound but medically undesirable as well. It would also involve the Federal government deeply in the problem of control over hospitals and nursing homes and the practice of surgery.

Finally, this is the wrong way to do it; the problem is already being solved through the initiative of individuals, medical societies, and insurance plans. Prior to December 1958, only six Blue Shield plans offered nongroup enrollment to persons over 65. Today only eight of the 67 plans, with two per cent of the total enrollment, have *not* yet formulated plans to care for this age group; 32 plans, with half the national membership, are handling them now, and 15 more are on the verge of doing it.

Commercial plans are pitching in too. Five years ago only five per cent of commercial plans allowed continuation of health insurance past age 65; today, 70 per cent permit it. Free competition, that famous American problem-solver, will solve this problem too, if Congress will just sit back and allow it to do the job.

By now, the Forand Bill may already be law—or it may have been defeated. But please don't take a chance. This is too important. Write to Honorable Dan Inouye, House of Representatives, Washington, D. C., and tell him briefly how you feel about the bill. And tell him why. It won't take more than a few minutes of your time. And it is important that our representatives in Washington—now that we have them, and they have a vote—know how physicians in Hawaii feel about legislation affecting health, hospitals and medical care. This is a vital part of the new responsibilities that have been placed upon us by statehood. Please—*do it now!*

Infant Death Case Study No. 3

This infant weighed 5 lb. 12 oz. at birth, which occurred four minutes after artificial rupture of the membranes, after 40 weeks' uneventful gestation. Labor lasted three and a half hours; breathing was spontaneous. It was the mother's fourth pregnancy; one had ended in spontaneous abortion and one in stillbirth, thought to have been due to a twisted cord.

Mother's temperature ranged from 101° to 102° postpartum, with Gram positive cocci and Gram negative rods in the urinary sediment, but negative urine cultures and otherwise normal urine. She improved with Gantrisin.

The infant left the nursery in good condition at five days of age, but became irritable and had a fever the sixth day, without abnormal physical findings. Spinal tap at another hospital showed 2,000 cells per mm^3, 64 per cent of them polys. Sugar was 40, proteins 160, and chlorides 679, mg per cent. Smears showed Gram positive cocci but cultures were sterile. Hemogram and urine were normal. Blood cultures were not done.

Chloramphenicol (75 mg IM stat and b.i.d.), sulfisoxazole (Gantrisin) (150 mg orally stat and 130 mg/Kg/day), and streptomycin palmitate (65 mg IM stat and 90 mg/Kg/day for ten days, then the succinate orally, 55 mg/Kg/day) were all started simultaneously. On the nineteenth day chloramphenicol was changed from IM to oral and on this day the total dose was 275 mg.

Spinal tap at 16 days of age showed only 59 cells per mm^3, mostly lymphocytes. Late on the nineteenth day the infant suddenly became pale and stopped breathing; blood pressure was unobtainable and temperature was 96.4° F. rectally. Liver was felt four fingerbreadths below the rib margin and rales were heard in the chest, though a portable chest radiograph was normal. Digoxin 0.1 mgm was given IM followed by 0.03 mgm every six hours for three doses. Adrenal cortical extract and hydrocortisone were given IV, followed by Levophed 2 cc in 500 ml 5 per cent glucose in water. Twelve hours after onset of acute distress the infant vomited and expired.

At autopsy, the brain was normal, the liver enlarged, and the peritoneum and pleural sacs were dry; heart, spleen, and adrenals were normal. The kidneys suggested early subcortical necrosis. Trachea and bronchi contained some mucoid material and gastric contents. All lobes of the lungs floated in water. Final pathologic diagnoses were:

Partial atelectasis of both lungs
Aspirated gastric contents in both main bronchi
Hemorrhagic necrosis of renal pyramids
Patchy congestion of liver

Although gross pathologic findings suggested aspiration as the cause of death, clinically this seemed merely agonal; the shock-like picture was thought to have had some other cause. Autopsy findings indicated, as did the clinical picture, that the meningitis had been successfully treated.

Fatal cardiovascular collapse following large doses of chloramphenicol (over 200 mg/Kg/day) has recently been reported in newborns. Very high blood levels have been found, moreover, in infants receiving only 50 to 100 mg/Kg/day. Perhaps these high levels result from inability to conjugate the antibiotic or to excrete the toxic conjugated products. In newborn infants the immaturity of the enzyme systems in the liver and the functional immaturity of the kidneys must always be considered. The same holds true of infants with any form of circulatory insufficiency.

Classification: A pediatric death, preventable, probably due to overdosage of chloramphenicol.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

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Dosage: One tablet four times daily usually for five days.
When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid.
Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.
Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY
Pearl River, New York



ORCE INJURY

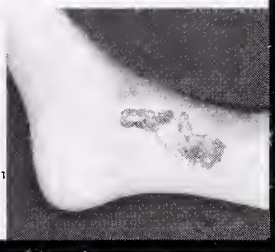
severe bruises
. . . swelling
. . . cleared
by fifth day[2]





VARICOSE ULCER

15 years duration
. . . resolved with
VARIDASE[1]





INFLAMMATORY DERMATOSIS

rapidly spreading
rhus dermatitis
healed within
a week[1]





INFECTED LACERATION

arked reversal
in 3 days . . .
returned
to school . . .
sure advanced[1]





THROMBOPHLEBITIS

back on his feet
in a week after
recurrent episode[1]





REFRACTORY CELLULITIS

normal routine
resumed after 4 days
of VARIDASE[1]



GROWTH

is a many-splendored thing

For nearly 22 years, Hawaii Medical Service Association (HMSA) has been the chief source of help for the people of our Islands in the payment of doctor and hospital bills. Over the years, HMSA has assuredly become a standard part of thousands of family budgets. Now, more than 170,000 people in Hawaii participate in this *kamaaina* community service program.

The fact that HMSA has grown by leaps and bounds is not surprising. For HMSA is not a profit-making insurance company. Neither is it a government agency. It's exactly what its founders intended it to be . . . a voluntary community association or *hui* through which its members can prepay their doctor and hospital bills on a *predictable, budgetable* basis. That's why it's not strange that as more and more people learned about HMSA, they wanted to become members.

An important part of this growth has been the support of Hawaii's medical profession. Through their cooperation, our doctors have solidly demonstrated their concern for the community's needs in health care. We feel sure the public *realizes* and *appreciates* this.

HAWAII MEDICAL SERVICE ASSOCIATION

Blue Shield Plan for Hawaii

Member, Western Conference of Prepaid Medical Service Plans

HONOLULU.....1154 Bishop St. — Phone 66-151
HILO.....P. O. Box 1356 — Phone 51-855
WAILUKU.....P. O. Box 256 — Phone 323-912
LIHUE.....P. O. Box 27 — Phone 22-201



In Memoriam -- Doctors of Hawaii -- XXIV

This is the twenty-fourth installment of In Memoriam—Doctors of Hawaii.

Franklin August St. Sure

Franklin August St. Sure was born April 25, 1874, at Oroville, California. He was the son of Franklin Augustus and Ellen (Donohue) St. Sure. His mother, born in County Cork, Ireland, and his father, born in Gothamburg, Sweden, Gothamburg, Sweden, came to the United States and settled first in Tennessee and later in Oroville.



DR. ST. SURE

He attended elementary and high school in Alameda, California. His medical degree was received from Cooper Lane Medical School in 1900. His internship was served at Alameda County Hospital, Hayward, California.

Dr. St. Sure served in the Spanish-American War with the 8th California Volunteers.

In September, 1904, following his discharge from the service, he came to Hawaii. His first position was at Eleele, Kauai, where he was a plantation doctor. In 1905 he went into private practice at Wailuku, Maui. He then moved to the Parker Ranch, South Kohala, Hawaii, and from there to Kaneohe, Oahu, to become doctor for the Libby Cannery and plantation doctor for Waimanalo Sugar Company and Heeia Plantation. In 1922 Dr. St. Sure returned to Maui as Territorial and County Physician and doctor for Libby, McNeill and Libby, Haiku Pineapple Company, and Maui Agricultural Company where he served for 26 years.

Dr. St. Sure married Mabel Alice Mossman December 21, 1904. They had five sons: John, Frank, Jr., Robert and George (twins), and Richard.

The doctor was interested in law and was licensed to practice in the District Courts of Hawaii. As hobbies he enjoyed collecting stamps and coins.

Dr. St. Sure died June 22, 1948, at Hamakuapoko, Maui, at the age of 74.

He was a 32° Mason, Lodge #472 F & AM, Maui; member of the Oakland Elks Lodge; Veterans of the Spanish-American War; American Medical Association, and the Territorial Medical Association.

In an editorial from the June 22, 1948, edition of the *Maui News* the following tribute is paid to Dr. St. Sure: "Dr. St. Sure came to Hawaii in the horse and buggy days of medicine, when the plantation physician was doctor, counsellor, and family friend to all the countryside . . . He lived to tell of the good old days and to witness the transition of the practice of medicine into a stream-lined era, but he never lost the homey philosophy, nor the patient demeanor of the American family doctor of an age now passed. Frank St. Sure leaves a rich heritage to those who survive him, a name honored in his community and his profession."

Henry L. Curtis

Henry L. Curtis, born in 1859, received his medical degree from the University of Pennsylvania School of Medicine in 1880.

In 1885 Dr. Curtis was appointed Government Physician for Hana, Maui, where he remained until 1890. By 1923 he was living in San Francisco, California, where he was a member of the city's Board of Health for many years.

Dr. Curtis died in San Francisco on October 3, 1938, at the age of 79.

Victor James Capron

Victor James Capron was born in 1867 and graduated from Jefferson Medical College, Philadelphia, in 1888.

Dr. Capron practiced as a government physician in the Kau district of Hawaii from 1893 to 1898 with headquarters at Naalehu. In March, 1898, he and his wife left for Seattle, Washington.

When the doctor became the patient, it was news, as illustrated by the following item from the *Advertiser* of January 28, 1898: "The latest steamer from Hawaii brought news of the very serious illness of Dr. Capron of Kau. He was poisoned by eating cheese."

The 1923 Medical Directory lists Dr. Capron as practicing at Friday Harbor, Washington, where he made his home until his final illness. He served on the Washington State Board of Health, was a member of the state legislature, and served as Mayor of Friday Harbor.

Dr. Capron died November 16, 1934, in Seattle at the age of 67.

Karl Reinhardt Hofmann

Karl Reinhardt Hofmann was born at Skassa, Saxony, Germany, on June 6, 1869, the son of Friedrich August Ernst and Mathilde (Germann) Hofmann.

He was educated at the Royal Gymnasium at Meissen, Germany, and received his medical degree from the University of Leipsig in 1894.

Dr. Hofmann started his practice as an assistant at a surgical clinic in Dresden in 1895. He became physician for the North German Lloyd line from 1898 to 1899. In 1900 he arrived in Hawaii and became physician for the Oahu Sugar Company at Waipahu, Oahu, a position he held until 1906 when he went to Kauai to become physician for the Makee Sugar Company at Kealia. While on Oahu he served as government physician for the Ewa district, and on Kauai he served the Kawaihau district in the same capacity. In 1916 he moved to Hawaii and accepted a position as physician for the Hawaiian Agricultural Company at Pahala and was also government physician for the Kau district.

Miss Elizabeth Brunnemann of Meissen, Germany, and Dr. Hofmann were married in Honolulu on October 15, 1901. They had four children: Mathilda L., Barbara K., Horst Reinhard, and Brigitte K.

Dr. Hofmann died in Honolulu on February 17, 1921, at the age of 51. He had been retired for some years prior to his death.

He was a member of the Hawaii Medical Association.

Book Reviews

Cerebral Palsy

By Joseph D. Russ, M.D., and Hyman R. Soboloff, M.D., 77 pp., $4.00, Charles C. Thomas, 1958.

The material presented is rightly named a "primer" on cerebral palsy. The authors have done a creditable job in condensing the subject to a form for assimilation by the busy practitioner. The reader will obtain some appreciation of the scope of present day systems of treating or *managing* the many personal and environmental problems which present themselves once the diagnosis has been established. The need for the team approach is properly stressed.

The reader will certainly be confused by the material on the classification of the various and sundry clinical pictures that are lumped together under the heading of cerebral palsy. The classification is a contradiction to the authors' statement that, "The characteristic thing about cerebral palsy is that it is a well defined entity with a variety of etiologies and pathologies."

The book is deficient in its failure to include the vitally important aspects of differential diagnosis. To the extent that the term "cerebral palsy" is still a "catch-basket diagnosis" for a wide variety of clinical syndromes of sundry origin, no child should be thus labeled without careful evaluation by a neurologist for ruling out removable causes for neuromuscular signs and symptoms.

The book is over priced.

R. Frederick Shepard, M.D.

★An Atlas of Cardiac Surgery

By Jorge A. Rodriguez, M.D., 250 pp., $18.00, W. B. Saunders Company, 1957.

This is a remarkably well illustrated and timely volume which, for the first time, presents under one cover an excellent outline of the accepted cardiovascular procedures. It should be in the reference library of every hospital and medical society. General surgeons would do well to study it carefully.

C. M. Burgess, M.D.

★Endocrine Pathology of the Ovary

By John McLean Morris, M.D., and Robert E. Scully, M.D., 151 pp., $8.50, The C. V. Mosby Co., 1958.

This is a *must* for pathologists and is strongly recommended reading for gynecologists who plan to keep abreast in their field. Possibly, it would interest pediatricians or internists confronted by a clinical picture of an endocrine abnormality. The text is chiefly concerned with hormone-producing tumors but to a lesser extent non-neoplastic cysts and hyperplasias of the ovary are considered. The authors are obviously "lumpers" as evidenced by their unique classification of tumors. What they call *lipid cell tumors* includes adrenal rests, luteomas, virilizing tumors, hilus cell tumors, etc.; *Sertoli-Leydig cell tumors* are arrhenoblastomas, and so forth.

The book is generously illustrated with microphotographs of very good quality. There is a succinct and informative chapter on hormone assay. Brief illustrative case histories are included but hardly worth reading; the meat of the book is in the other material.

Raid Chappell, M.D.

★ Means "highly recommended"

General Urology, 2d Ed.

By Donald R. Smith, 328 pages, $4.50, Lange Medical Publications, 1959.

Written in outline form, this paper-backed book is, as indicated in its preface, "written for the medical student and medical practitioner who has not specialized in urology." As such it is a well-organized, up-to-date, and authoritative publication that covers the vast majority of both common and uncommon urologic disorders. Standard diagnostic methods are covered, and accepted methods of treatment indicated. For detailed urologic technics the practicing urologist should look elsewhere, but for medical students and house staff this text will continue to be of great value.

W. S. Strode, M.D.

Group Psychotherapy, 2d Ed.

By J. W. Klapman, M.D., 301 pages, $6.75, Grune & Stratton, 1959.

This book represents a current and competent overview of group psychotherapy in its many variations and applications. Ranging from intensive small-group analysis all the way to mass re-education through didactic lecture and evangelical exhortation, the author covers the field well in breadth if not in depth.

This second and up-to-date revision of a work that has become a standard in this fast growing field will be of interest to individual and group therapists as well as those in allied professions having need for group treatment methods.

William H. Stevens, M.D.

Evaluation of the Pelvis in Obstetrics, 2d Ed.

By Charles M. Steer, M.D., Med.Sc.D., F.A.C.S., F.A.C.O.G., 131 pp., $4.00, W. B. Saunders, 1959.

This second edition is a small book of 123 pages to be read by obstetricians, general practitioners, and roentgenologists.

Some parts are purely didactic, especially those sections dealing with pelvic morphology and the mechanism of labor.

The clinician's interest would be centered on the sections dealing with clinical examination of the pelvis which is certainly worth studying. Pelvic arrests from the midpelvis to the outlet in the various types of pelves are fully described and their treatment discussed.

The section on x-ray pelvimetry is interesting to those fully versed in this work.

On the whole, this book is worth reading by those participating in the care of laboring patients.

Satoru Nishijima, M.D.

★Atlas of Technics in Surgery

By John L. Madden, M.D., F.A.C.S., 648 pp., $30.00, Appleton-Century-Crofts, Inc., 1958.

This atlas as edited by Dr. Madden and with an imposing array of 62 contributing authors, all of whom are outstanding leaders in the field of surgery, is an impressive volume. The introductory chapters on pre- and post-operative care, fluid and electrolyte balance, and anesthesia are succinct and contain a wealth of valuable

(Continued on page 344)

This is What's New in Russia!

From *The Pathogenesis and Immunology of Tumors,* Pergamon Press, 1959: (Translated and published with the assistance of the Pergamon Institute and the National Institutes of Health.)

"New definition for the main subject of study in our science will embrace not only the disease itself, cancer, chondroma, or whatever tumor it may be, but also the individual in which, **by virtue of disturbance in the controlling influence of the nervous system,** the process has arisen." N. N. Petrov, p. 7.

From the Virology Division of the Gamaleia Institute, successful heterotransplantation of carcinoma is reported. **"Rabbit carcinoma** was successfully **transplanted into the brains of mice,** with about a quarter of the transplants growing in the host. The heterotransplants, even after serial passage through nine generations of mice, retained their original histologic characteristics. The reverse inoculation, from mouse brain back into the rabbit, was also successful." V. N. Stepina, p. 25.

Studies on breast tumors "confirm the **virus nature of the milk factor** which manifested its pathogenicity for noncancer-strain mice after prolonged culture through a number of passages on chick embryo." (The milk factor obtained from cancer strain mice **causes breast cancer** in low cancer strain.) P. Ia. Smoilovskaia, p. 39.

"The presence of **specific antigens** which are absent from the tissues of the corresponding organs in healthy individuals was demonstrated in **cancers of the stomach, esophagus, pancreas, uterus, ovaries,** and **mammary gland of man.** The presence of antibodies to the specific antigens of tumors could be demonstrated by means of passive anaphylaxis." (These conclusions were reached after a series of experiments in which guinea pigs were sensitized by the subcutaneous injection of protein extracts of human malignancies.) V. V. Gorodilova and L. V. Shershul'skaia, p. 101.

Artificial immunization against carcinoma by the use of a vaccine prepared from tumor cells is partially successful. The carcinoma antigen is freed from the tumor cells by the use of immune serum. The immune serum causes destruction of the tumor cells but preserves the antigenicity. Conclusion: "The **prophylactic vaccination** of rabbits against **Brown-Pearce carcinoma** can be effected with a vaccine containing the antigens extracted from tumor cells and free from living tumor cells themselves." Note: As many vaccinated as unvaccinated control animals developed the carcinomas, but the survival period of the vaccinated rabbits was considerably longer. R. M. Radzikhovskaia, p. 237.

From *The Central Nervous System and Human Behavior:* (Prepared and distributed by the Russian Scientific Translation Program, National Institutes of Health, Bethesda, Maryland, 1959.)

The central reorganization of brain centers was proved by the anastomosis of two different types of nerves. "The central end of the **vagus** nerve of a dog was sutured to the peripheral end of the **axillary plexus.** After [some months'] recovery, **scratching the dog's forefoot caused reflex vomiting and coughing.** After about twelve months, however, similar stimulation caused a **defense reaction of the legs, and whimpering.** The medulla . . . so reorganizes its work that it completely replaces the work of the coordinating centers formed embryonically in the segment of the spinal cord corresponding to the axillary plexus." P. K. Anokhin, p. 16.

"If **decortication** of mammals (kittens and puppies) is performed at an early age, under 1.5 months, the **cerebrum regenerates completely** and the same functions are manifest as occur in normal animals." A. B. Kogan and N. N. Dzidzifhvili, p. 18.

Biological reflexes are represented in the subcortical portion of the brain. "These are always represented in **two opposite forms** with the predominance of excitation or inhibition in each of them: for example, waking-sleeping, swallowing-vomiting, thirst-hydrophobia, acquiescence-worry, libido-frigidity, etc. By cerebral cortex extirpation and selective destruction or stimulation of the brain stem, **24 pairs of complex reflexes** were identified. These reflexes were classified as follows: (1) reflexes of **general activity;** (2) **metabolic** reflexes; (3) reflexes of **relationships** with other animals; (4) reflexes for **continuation of the species;** (5) **ecological** reflexes; and (6) miscellaneous reflexes." N. A. Rozhansky, p. 19.

"Blind children, and normal children with sealed eyelids, are capable of **spatial orientation,** but deaf-mute children with **nonfunctioning labyrinths** do not have this capacity if their eyes are closed." I. Beritov, p. 30.

"The problem of **feelings and emotions,** despite its current importance, is **least** well worked out in Soviet psychology." A. G. Kovalev, p. 61.

"Corticovisceral physiology, developing as a result of the most important beginning by Pavlov, makes it possible at present to [advance] the **materialistic** concept of the **interconnection between the psyche and the somatic** in medicine [as opposed to] the foreign idealistic percepts which have recently become so widespread in the bourgeois countries and especially in the U.S.A." D. A. Birukov, p. 193.

The above excerpts, subject to the obvious criticisms of awkward if not erroneous translation, reflect some lines of investigation in Soviet medicine. Some results are unbelievable; some even more unbelievable than photographing the far side of the moon.

F. I. Gilbert, Jr., M.D.

Notes and News

Doctors and Our Community

Saving lives through medicine isn't enough for **Dr. Robert R. Simpson** of Aiea, who is training to become a Red Cross Water Safety Instructor.

Recently, two Catholic laymen of Honolulu, **Dr. John M. Felix** and Mr. Joseph H. O'Donnell, were honored by Pope John XXIII with one of the highest awards laymen can achieve in the church—Knight Commander of the Order of Pope St. Sylvester.

Dr. Linus Pauling, Jr., the Queen's Hospital mental health clinic director, conducted a course in "Personality, Its Development and Function" at the Y.W.C.A. in September.

Dr. Howard Liljestrand showed his film, "Cinerama From The Rear," at the Honolulu Gas Company Building to the Movie Club of Hawaii.

Dr. Richard You was the physician for the Girls' and Women's National Track Championships in June in Cleveland.

Dr. Kenneth Ho, and family and **Dr. Theodore Tomita,** and family, were prominently pictured in our local papers during the Thanksgiving Holidays celebrating their family get-togethers.

Dr. Fred Gilbert took over Kini Popo's show on the TV on October 20 and people are still talking about it.

The Yale Club of Hawaii has elected **Dr. Charles S. Judd, Jr.,** as its President.

Dr. Clarence E. Fronk, the horse's friend, wrote the editor of the *Honolulu Advertiser* on October 1, 1959, how he kept his horses on the eighth floor of an apartment for horses only, when he was a resident of Boston, Massachusetts.

Dr. and **Mrs. John W. Devereux** recently celebrated their 25th wedding anniversary at their home with a large gathering of their friends.

Drs. Marie and **Robert B. Faus** were honored recently by more than 600 Aloha Temple Shriners whom Dr. Faus leads.

On November 1, 1959, *The Honolulu Star-Bulletin* featured a story on **Dr. Steele F. Stewart,** a retired Honolulu physician formerly with the Medical Group. He now has a fascinating work, helping clients of the International Travel Service plan trips to all parts of the world.

Dr. E. Wonsik You, anesthesiologist with The Queen's Hospital, and winner of the *Star-Bulletin* championship bridge tournament last June, and Mrs. You were recently the subject of nationally syndicated bridge columnist Howard Schenken's column for being the only pair to bid and make a grand slam in a mainland tournament.

During the recent opening of the Shirokiya store, **Dr. Kyuro Okazaki** was one of the board members on the receiving line.

Dr. Sumner Price was pictured working hard for the Lanikai community luau in the *Honolulu Advertiser* on November 11, 1959. He was shown holding a imu stone with Mrs. Bruce Howell.

Lectures

Dr. Richard K. C. Lee, President of the State Board of Health, was chosen to give the Winslow Lecture on October 26 at Yale University's Department of Public Health. His topic was "World Health and World Peace." The lecture is named for **Dr. C. E. A. Winslow,** who established the Department of Public Health in the Yale School of Medicine and who was internationally known as a public health worker.

At the annual meeting of the Hawaii Heart Association at the Sheraton Meeting House in September, **Dr. Scott C. Brainard** and **Dr. Bernard J. B. Yim** discussed open-heart surgery in the state.

Dr. William E. Mayer, psychiatrist with the Hawaii Mental Health Service, spoke on "Moral Aspects of Brainwashing" at the Community Church of Honolulu in July of this year.

Dr. Katherine Edgar, Chief, Bureau of Maternal and Child Health, Department of Health spoke on the School Health Services Evaluation Project, 1957-1958 during the Nutrition Institute sponsored by the Hawaii Dietetic Association, the Department of Health, and the University of Hawaii.

Three Honolulu physicians discussed allergy on TV on September 16, 1959. They were **Dr. Claude V. Caver, Dr. Archie Chun-Ming,** and **Dr. Clarence Y. Sugihara.**

Four Honolulu physicians discussed leprosy on TV on October 10, 1959. They were **Dr. Harry L. Arnold, Jr., Dr. Edwin K. Chun-Hoon, Dr. Grace H. Hedgecock,** and **Dr. Ira D. Hirschy.**

Dr. Robert C. Bell, Dr. Lucy Ma, Dr. Claude V. Caver, Dr. Richard Chang and **Dr. James Kuninobu** were the first panelists in a series of monthly forums on medical problems, sponsored by *The Advertiser* and the Honolulu County Medical Society. The topic on discussion was "Worry."

The second public forum was held on December 3 at the Mabel Smyth Auditorium. The topic was "Drugs —Miracle or Menace?" The physicians on this panel were **Dr. Archie Chun-Ming, Dr. William H. Stevens, Dr. John H. Peyton, Dr. Kenneth W. Momeyer** and **Dr. Claude V. Caver.**

Women

Doctors are famous for not practicing what they preach—and that is to get annual physical examinations. To put an end to this, the Woman's Auxiliary of the Hawaii Medical Association recently proposed a recolution to the medical assembly urging doctors to have yearly compulsory physicals. The *Star-Bullenti* on July 17, 1959 reports that the men voted to "accept the idea in principle" with the suggestion that the ladies follow through with their own suggestion.

Mrs. Howard Liljestrand, President-elect of the Woman's Auxiliary to the Hawaii Medical Association, attended the mid-year conference of the Woman's Auxiliary to the American Medical Association held in Chicago on October 4 to 7. This was the first time Hawaii has sent an officer to the mid-year conference. The National Auxiliary requested that Hawaii and Alaska be represented this year.

Members of the Honolulu Medical Society Auxiliary made a telephone survey of 1,500 homes during the latter part of September, to determine how many families were protected against polio. The survey was taken for the National Foundation. Among those assisting were **Mrs. George B. Garis, Mrs. Thomas Y. K. Chang** and Mrs. Frederick P. Whittemore, board member of the Honolulu Chapter of the National Foundation.

The 28th Annual Convention of the Hawaii Nurses' Association was held on October 15 to the 17 at the Mabel L. Smyth Memorial Building. Over 400 members and nonmembers, including 60 delegates from Oahu, Kauai, Hawaii, Maui, Molokai, and Lanai attended the meeting. This year's theme was "Nursing Meets Personality Needs."

Change of Scene

Dr. Wolfgang G. Pfaeltzer announced the opening of his office in Kahului, Maui, in August, 1959.

Dr. Akira Kutsunai announced the opening of his office at 1507 South King Street in September, 1959.

Dr. George H. Nip announced the resumption of practice in October, 1959.

Drs. J. Dempsey Huitt, William M. H. Dung, Philip T. Chu, Cesar B. de Jesus, Henrietta Tompkins, Harold McKeen, Jr., announced their association with the Pacific Medical Associates with offices located in the Kaiser Foundation Medical Center.

Dr. Alan K. Luning announced the resumption of practice in September, 1959.

Dr. Masaru Koike announced the opening of his office at 1507 South King Street in September, 1959.

Dr. Henry A. Manayan announced the opening of his office at 311 South Vineyard Street in August, 1959.

Dr. Jeanette H. J. Chang announced the opening of her office at The Alexander Young Building in October, 1959.

Dr. Edmund L. Lee announced the resumption of practice in October, 1959.

Dr. Shigeo Natori announced the removal of his office to 2519 Coyne Street.

Dr. Noboru Oishi announced the opening of his office at the Medical Arts Building in November, 1959.

Dr. Wallace W. S. Loui announced the opening of his office at the Professional Center Building in June, 1959.

Dr. Maurice A. deHarne and **Dr. H. M. Chandler** announced the opening of their office in the Wahiawa Shopping Center in August, 1959.

Dr. Samuel J. Buist announced his association with the Medical Group in August, 1959.

Dr. Robert P. C. Ho announced the removal of his office to 1507 South King Street in June, 1959.

Dr. Teru Togasaki announced the resumption of practice.

Dr. Milton Trager announced the opening of his office at 305 Royal Hawaiian Avenue in June, 1959.

Dr. Robert K. Mookini, Jr. announced the opening of his office at 914 Keeaumoku Street in September, 1959.

Dr. Victor Motojiri Mori announced the opening of his office at 1319 Kalakaua Avenue in September.

Dr. George D. Oakley announced his association with **Drs. Dickson, Cushnie,** and **Chung-Hoon** at 238 Young Hotel Building.

Dr. Robert A. Spicer announced his association with **Dr. Pershing S. Lo** at 1531 South Beretania Street in July, 1959.

Dr. Herbert M. Nam announced the opening of his office in association with **Dr. Richard W. You** at 1282 Emma Street.

Dr. Richard S. Omura announced his association with **Dr. Verne C. Waite** at 350 South Hotel Street in July, 1959.

Lt. Larry J. Otterness was assigned to the Hickam Air Force Base dispensary as an Air Force doctor.

Hawaii Medical Association

Report of the A.M.A. Delegate

Medical Services Conference

The A.M.A. Council on Medical Services sponsored a meeting on Medicare, Public Welfare Medical Service, Federal Employees' Health Insurance, and Health Insurance for "Over 65" in Dallas last November 30.

Medicare

General Floyd Wergeland spoke on the imminent restoration of Medicare services; the cuts, he said, had proved unexpectedly deep. Though only half the beneficiaries had returned to Army care, the cost had dropped from $8.5 to $3.5 million dollars a month.

Congress is expected momentarily to restore services for:

- Injuries (in ambulatory patients)
- Hospitalization for injuries and surgery
- Emergency care of emotional disorders for 21 days only (with exceptions if sponsor is overseas)
- Elective surgery (tonsils, hernias, gynecological diseases)

Permits for patients residing with the sponsor will be issued on the authority of the local Commanding Officer, and obstetrical permits will be issued, as a rule, only if the patient does not reside with the sponsor.

Public Welfare Medical Care

This complex subject cannot be reported on in detail here; it would fill this issue. The tendency the country over is toward fee for service, with free choice of physician except where care is furnished in hospitals with residency programs.

Drugs can bankrupt a program, and restriction is necessary; in California, expensive drugs are restricted by specific diseases; inexpensive drugs are on an unrestricted list. In another area, drugs can be dispensed, but approval is required for refills.

Outpatient surgery can be too expensive, and is limited in California to urgent and emergency procedures.

California's fees vary county by county, from $3.99 to $7 per unit on the Relative Value Scale; overall average, $5. "Prior authorization" (for over 3 visits in any 90-day period) proved unworkable and has been entirely abandoned.

Florida donates all fees received to the Florida

Medical Foundation. Illinois provides "complete essential" care, but limits it to two office calls a month for chronic illness, six for acute, and $2 a day for the first ten days in the hospital, then $2 for two visits a week. Surgery fees are scheduled. Overutilization and drugs have been serious burdens, and drugs running over $5 per hundred, per pound, or per pint require authorization.

John Steen of Seattle said they'd found free choice far cheaper than county hospitals, and they have both. Only 10 per cent of their doctors refrain (optionally) from participation. In one county, 11,000 indigents get their care for $35.000 a month.

Further details have been transmitted to our committee.

Federal Employees' Health Insurance

Next July, Federal employees and their dependents (close to 80,000 persons in Hawaii) will have half the premium cost of their chosen medical care plan paid by Uncle Sam. Recognized will be:

1. Nationwide service plan (Blue Cross and Shield) with major medical but without home and office care
2. Nationwide indemnity plan (Aetna)
3. Employee organization plan (none in Hawaii)
4. Comprehensive plans
   a. Group prepayment (Kaiser, e.g.)
   b. Individual prepayment: service plan with no income ceiling.

Eligible will be all but some 2,000,000 temporary or seasonal Federal employees; 90% of the others (some 4,000,000 in all) are expected to sign up.

A tentative form for comment and criticism should be available by now, and a final form and contracts are to be ready by February 1. Benefits will be limited to: hospitalization, surgery, home and office care, obstetrical care, and drugs and appliances; not all plans need cover all these features.

Uncle Sam will bear half the cost of average priced plans, and no more than this sum for any plan: if there is a differential the employee must pay it by payroll deduction. This is expected to amount to about $2.80 monthly for one, or $6.75 for one plus a dependent, by which is meant only a spouse, a child under 19, or a disabled child of any age. This will cost almost $250,000,000 annually, half of it from the government. Annuitants and survivors after two to five years will probably be allowed to carry the plan into retirement.

Plans can be switched annually. Leave without pay (for illness, e.g.) up to one year is covered by all plans. Duplicate coverage will be severely discouraged—a prohibition which was sharply and openly criticized by many present.

The uniform nation-wide fee schedule and premium rate planned for both Blue Shield and commercial plans puzzled everyone. It seems to mean either wholesale resignations from Blue Shield participation in high fee areas, or a shocking "gravy train" for physicians in low fee areas. Also, closed panel plans will be allowed to negotiate locally, not at the national level as will be required of the country-wide plans. State-by-state flexibility among Blue Shield plans was thought to be possible for service benefits only.

Health Insurance for "Over 65"

Iowa's attempt to implement A.M.A. recommendations in this field has been fairly successful; they use the Relative Value Plan with a $5 unit for office and home visits and $2 (soon to be raised to $3) for surgery, laboratory and x-ray, with 30 days' hospitalization, for persons over 65 whose income is less than $2000 (or $3000 for a couple) and whose net worth is under $20,000 (or $30,000 for a couple). Hospitals get full cost instead of full cost plus 5% as formerly. The Shield premium is $3.05, the Cross $5.30, monthly. They only sold 8,000 policies to 350,000 eligible persons of whom 60,000 already had a Blue plan.

Florida (with 11% of people over 65 instead of 3% as in Indiana!) has asked Blue Shield to handle the coverage; their indigents, including those over 65, are already well cared for. Indiana's costs for the older group are nearly four times the cost of their younger group; their Blue plans have no age limit, and the premium is $4.85 to $6.80 a month (no hospital benefits). They have no service plan: only indemnity.

Nationally, only eight Blue plans, with 2% of the total enrollment, make no provision as yet for the "over 65" group, and the 5% of commercial plans who carried beneficiaries past age 65 five years ago has risen to 70%. Commercial plans would like the medical profession to define "reduced circumstances" and to advocate free choice among insurance plans.

Dr. Robert Novy of Michigan warned that criteria for acceptance, and benefits, vary so widely among plans that comparison of premiums is almost impossibly complicated. It was pointed out, too, that a 50% reduction in doctors' fees may permit only a 10 to 15% reduction in premiums.

A.M.A. "Clinical" Session

Among several lesser actions taken during the two and a half day "Clinical" Session of the A.M.A. in Dallas, December 1-3, 1959, the House of Delegates

Adopted unanimously, without reference to committee, the following resolution, introduced by Dr. W. D. Stovall for the Wisconsin delegation:

WHEREAS, The territories of Alaska and Hawaii have recently become the 49th and 50th States of the Union; therefore be it

Resolved, That the American Medical Association offer congratulations and a sincere welcome to the state of Hawaii and the state of Alaska and to their respective state medical associations as members of the American Medical Association; and be it further

Resolved, That the delegates of this House of Delegates extend their personal greetings to their fellow delegates from the sister state associations of Alaska and Hawaii with the hope that this new affiliation cultivates even closer fraternity among the profession and greater opportunity for continued improvement of the health of the people of these states; and be it further

Resolved, That these expressions of good will and best wishes be transmitted to the Governors of Alaska and Hawaii and to the officers and members of the Alaska and Hawaii medical associations.

Then, after the usual day of reference committee hearings, the House reconvened and in the final half-day session

Amplified the Free Choice of Physician decision made at Atlantic City last June by adding this paragraph:

"Lest there be any misunderstanding we state unequivocally that the AMA firmly subscribe to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows or abridges such freedom of choice and such competition."

Reaffirmed the 1951 Guides to Relationships Between Physicians and Hospitals (in response to 12 resolutions to this effect).

Urged

That county medical societies discipline members who deserve it.

That pilot fitness examinations be done only by qualified physicians appointed by the Civil Air Surgeon.

That every person be advised to get tetanus immunizations.

That county and state medical societies sponsor inspection and testing programs for all fluoroscopes and radiographic equipment.

Limitation of veterans' care for nonservice-connected disease at government expense to veterans genuinely unable to pay for it—and free choice of physician or institution for service-connected problems.

Use of M.D. after a doctor's name, in preference to Dr. before it, wherever appropriate.

That literature be placed in libraries of all public and private schools, explaining the advantages of private medical care.

Continued support of the American Medical Education Foundation (A.M.E.F.).

Ordered

Appointment of a committee to investigate the use of ambulatory patients for teaching in hospital educational programs.

Appointment of a committee to facilitate and promote the study of medicine and induce more students to enter into it.

Investigation of the need for a home for elderly retired physicians.

Objected to the Forand Bill, as unnecessary and unwise.

Pointed out that of 72 items of medical or related legislation before the first session of the 86th Congress, the AMA had been heard on 19, of which it supported 14 and opposed only one—the Forand Bill.

Since I was appointed a member of the Reference Committee on Miscellaneous Business, it was impossible for me to attend the sessions of the other committees and participate in the discussion there. On every item of business before the house, however, throughout the whole session, I voted—as it turned out, and whether wisely or unwisely—with the majority.

HARRY L. ARNOLD, JR., M.D.
A.M.A. Delegate

MINUTES OF THE COUNCIL MEETING

November 18, 1959, at 6:30 p.m.
Ciro's, Honolulu

PRESENT

Dr. Toru Nishigaya, presiding; Drs. Allison, Bergin, Burgess, Cushnie, and Mizuire, plus guests Drs. Harry L. Arnold, Jr., and Mr. Richard M. Kennedy.

MINUTES

The minutes of the July 23, 1959, meeting were approved as published.

INTERIM COUNCIL ACTIONS

Dr. Nishigaya explained that it had been necessary to get the Council's approval by written ballot on three matters. With this approval he had (1) written to the Governor and the Legislature urging that the Department of Health not be amalgamated with the Department of Social Services, (2) changed the dates of the annual meeting to May 12 to 15, 1960, in order to avoid conflict with other large meetings, and (3) authorized expenditure of funds to cover the hospitality room which the Hawaii Medical Association co-sponsored with the Honolulu County Medical Society during the November meeting of the Western Conference of Prepaid Medical Plans.

ACTION:

It was voted that these three actions be inserted in the minutes.

ANNUAL MEETING

Dr. Nishigaya gave an interim report on the activities of the Arrangements and Scientific Program Committee. He said they had decided that because this will be our first meeting under statehood that they should do a bang-up job and exert every effort to make it an outstanding occasion. It looks as though we will have four mainland speakers. Almost three hundred letters were

(Continued on page 336)

County Society Reports

Maui

The regular meeting of the Maui County Medical Society was called to order at 8:30 P.M. by the President, Dr. L. T. Kashiwa, on Tuesday, July 21, 1959, at the Central Maui Memorial Hospital. Guests present were: Doctors C. Henry Kempe, D. Kliewer, H. Zimmerman, Herbert Kashiwa, W. Pfaeltzer, M. Sowers, and M. Hanlon.

Dr. C. Henry Kempe, Professor of Pediatrics, Colorado Medical School, gave an interesting talk on Antibiotics and Virology.

Applications from Doctors Hanlon, Sowers, and Pfaeltzer were received and it was moved by Dr. Underwood and seconded by Dr. Burden to refer these applications to the Board of Governors for approval. Motion was passed unanimously.

A special meeting of the Maui County Medical Society was called to order by the President, Dr. L. T. Kashiwa, on Thursday, August 13, 1959, at the Central Maui Memorial Hospital.

There was some discussion regarding the present Maui Pine strike. Some members felt that there seemed to be some mistreatment of workers and felt that some of the doctors should go down to the Pineapple Company grounds and see for themselves the strike situation.

A special meeting of the Maui County Medical Society was called to order at 9:10 P.M. by the President, Dr. L. T. Kashiwa, on Thursday, September 10, 1959, at the Central Maui Memorial Hospital.

Dr. Tong discussed the amalgamation or combination of three departments: Department of Health, Department of Public Welfare and Department of Institutions, as set forth by the Interim Committee of the present legislature in its effort to cut down the number of departments from 80 to 16. He gave reasons for the wisdom of maintaining the Board of Health as a separate department. Dr. Burden moved to recommend that the Board of Health be a separate and independent department. It was seconded by Dr. Underwood. After some discussion, the motion passed with 17 ayes and 2 noes.

The regular meeting of the Maui County Medical Society was called to order at 7:45 P.M. by the President, Dr. L. T. Kashiwa, on Tuesday, September 22, 1959, at the Wailuku Hotel. Guests present were: Drs. D. Kliewer and Strothers (Mrs. Sowers).

A film on "No Margin For Error" was shown.

Dr. Kliewer gave a very enlightening talk on "Diagnosis and Treatment of Anemia."

Application for membership submitted by Dr. Herman Kramer was presented. The application had been reviewed by the Board of Governors and found to be in order. It was unanimously approved.

Dr. Burden gave a report on the HMSA meeting. HMSA has obtained 65 per cent of the *Star-Bulletin* employees whereas Kaiser has 34 per cent.

Dr. Kashiwa and Dr. McArthur gave a report on the recent meeting with the legislators in Honolulu. It was felt that Mrs. Dorothy Devereux should be invited to speak to the Society in the future.

It was urged that doctors attend Dr. Dooley's talk on "Operation Laos" on September 29, 1959.

There being no further business, the meeting was adjourned at 9:50 P.M.

A meeting of the Maui County Medical Society was held at the Wailuku Hotel at 8:30 P.M., Friday, October 2, 1959. Guest present: Dr. Killefer. The program was taken over by the Advisory Committee to the Bureau of Maternal and Child Health. Members present were: Doctors Edgar, Nakamura, Nishijima, Watt, Wyatt, Col. Zimmermann, and Lt. Col. Fairchild.

The subjects discussed were: "Toxemia in Pregnancy" and "Sudden Death in Infants."

The Society felt that much information was derived from this meeting and wants to express its appreciation to the members present for their talk and discussion.

A special meeting of the Maui County Medical Society was called to order at 9:30 P.M. on Thursday, October 15, 1959, at the Central Maui Memorial Hospital.

The Maui Pineapple Company and ILWU negotiations regarding a medical plan are underway. The ILWU is asking for free choice of doctors and medications (antibiotics and vitamins) at cost and acceptance of the fee schedule as full payment by the company doctor. In keeping with the discussion that followed, a letter from Dr. Nishigaya was read. It was felt by the Society as a whole that the procedure is discriminatory and unethical. It was moved by Dr. Fleming and seconded by Dr. Iaconetti that a committee of three be appointed by the President to write a letter to the ILWU, copies to be sent to Maui Pineapple Company and the Hawaii Medical Association, expressing our feeling in this matter. The motion was passed with one dissenting vote cast by Dr. McArthur. Dr. Fleming, Dr. Kashiwa, and Dr. Iaconetti were appointed.

The nominating committee composed of Dr. McArthur, Dr. St. Sure, and Dr. Shimokawa presented a slate for the 1960 officers as follows: President, Dr. A. Y. Wong; Vice President, Dr. C. F. Moran; and Secretary-Treasurer, Dr. S. Ohata.

A. Y. WONG, M.D.
Secretary-Treasurer

Hawaii

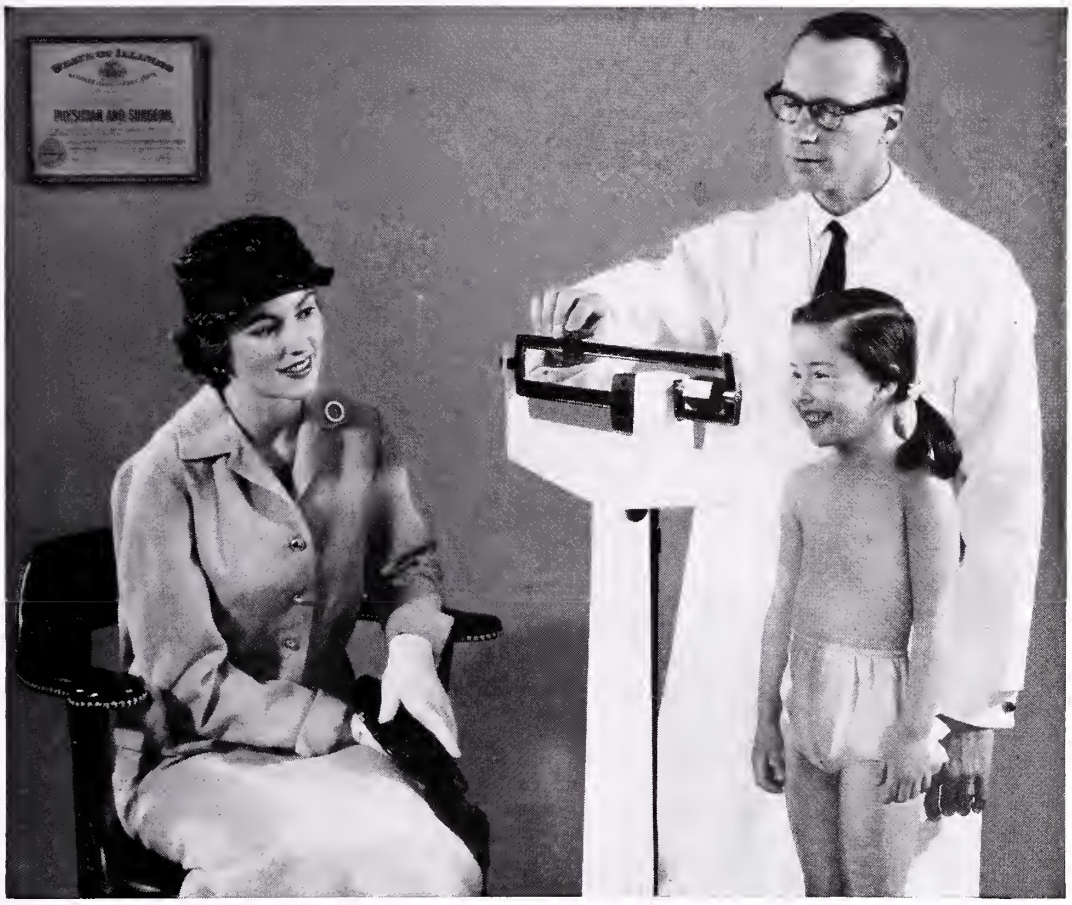
The October meeting of the Hawaii County Medical Society was held at the Hilo Hotel on October 15, 1959. Dr. Robert Kissling, Director of the Virus Laboratory of the State Health Department, was the guest speaker. He delivered an informative talk concerning laboratory diagnosis of common viral diseases.

At the business meeting which followed, the Medicare contract was discussed. A $5.00 fee for first visits and $4.00 fee for routine visits were recommended and unanimously approved by the Society. After the business meeting, the monthly meeting was adjourned.

Dr. Robert Emrick has moved to Honolulu, and has transferred his membership to the Honolulu County Society.

Eighteen members of the Hawaii County Medical Society met in Honokaa on November 18, 1959, for the monthly meeting.

(Continued on page 354)



Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.



SYMPOSIUM REPORT:

ALTAFUR in antibiotic-resistant staphylococcal infections

ALTAFUR proved superior to any other single agent against staphylococcal infections encountered in the pediatric section of a general hospital. Introduced during an epidemic of severe staphylococcal pneumonia and bronchiolitis in younger children, ALTAFUR was employed in treating a total of 59 infants or juvenile patients, most of whom had upper or lower respiratory tract involvement. Almost all had been given antibiotics without effect; 34 were judged severely or critically ill. Cures were obtained in 54 of these patients after a 3 to 10 day course of ALTAFUR. There was only one failure (results were inconclusive in the remaining four cases). Mixed infections with Pneumococcus or Streptococcus sp. also responded readily.

ALTAFUR was administered orally in varying dosage: the optimal dose is believed to be about 22 mg./Kg. daily.

Side effects were minimal in these patients, being limited to gastric intolerance in a few cases, usually controllable by giving the drug with or after meals. Laboratory studies performed before and after ALTAFUR treatment revealed no adverse influence on renal, hepatic or hematopoietic function, nor other signs of toxicity.

In vitro, staphylococci isolated in this series proved uniformly susceptible to ALTAFUR, whereas many strains were resistant to a variety of antibotics. With ALTAFUR as with all nitrofurans, the lack of development of significant bacterial resistance is considered a major advantage over other antimicrobials.

Lysaught, J. N., and Cleaver, W.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959 (published Nov., 1959)

bright new star

in the antibacterial firmament

ALTAFUR™

brand of furaltadone

the first nitrofuran effective orally

in systemic bacterial infections

- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
- Decisive bactericidal action against staphylococci, streptococci, pneumococci, coliforms
- Sensitivity of staphylococci in vitro (including antibiotic-resistant strains) has approached 100%
- Development of significant bacterial resistance has not been encountered
- Low order of side effects
- Does not destroy normal intestinal flora nor encourage monilial overgrowth (little or no fecal excretion)

Tablets of 50 mg. (pediatric) and 250 mg. (adult)
Average adult dose: 250 mg. four times a day, with food or milk
Pediatric dosage: 22-25 mg./Kg. (10-11.5 mg./lb. body weight daily in 4 divided doses

CAUTION: The ingestion of alcohol in any form, medicinal or beverage, should be avoided during Altafur therapy.

NITROFURANS—a *unique* class of antimicrobials
EATON LABORATORIES, NORWICH, NEW YORK

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

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KATSUKO ENOKI, *Associate Editor*
HAZEL KIM, *Associate Editor*
MILDRED KIM, *Associate Editor*

OLIVE C. PRIDGEN, *Executive Secretary*

Annual Meeting

Committee Assignments

As requested by the House of Delegates committees have been enlarged. As nearly as possible members were placed on the committees of their choice. These assignments were approved by the Board of Directors at their post convention board meeting. If you would like to serve on a committee and have not been assigned to it please notify the HNA office. Please save this list for future reference.

American Journal of Nursing
Yetta Fukuda
Margaret Nott
Florence Ayers
Mae Tokunaga
Martha Ohama
Hilda Yatsushiro
Alma Anton
Mary Nailau
Chieko Tanaka
Victoria Loo
Harriet Tonaki
Jean Sakai
Irene Saito

Blood Bank
Alma Anton
Chitsue Kunhaha
Judy Fujimoto
Lillian Teshima
Elvie Manley
Yukiko Higa
Sister Laurenza
Glayd Jacobs

Civil Defense
Eleanor Apo
Alma Takata
Susan Reichert
Mary Kleinkopf
Agnes Peterson
Alison MacBride
Sister M. Laurine
Olga Larson
Janet Sawaguchi

Constitutions & Bylaws
Betty Mitsunaga
Sister M. Evelyn
Sister M. Philip
Myra Campbell
Virginia Jones
Sister M. Petra
Alice Scott
Mabel Snyder
Fumie Uratani

Convention Manual
Flora Ozaki
Hazel Kim
Leona Adam
Doloros Winninger
Eunice Graham

Economic Security
Agnes Branco
Edyths Collins
Ethel Edgar
Elsie Rogozenski
Edna Chapman
Takako Hamasu
June Miura
Victoria Loo
Kazue McLaren
Marian Kwock
Ine Higa
Susan Reichert
Marjorie Moran
Edna Baldwin
Margaret Kleinkopf
Eleanor Apo
Esther Wagner
Helen Frederick
Hilda Akana

Finance
Thelma Hensley
Eunice Graham
Natsumi Hodson
Bernice Robeson
Clifford Burroughs
Julie Yueki
Alma Anton
Joan Huxy

International Relations
Phyllis Stubbs
Margaret Barnett
Sister Laurenza
Rebbeca Clark
Alice Healy
Marian Kwock
Leona Rubbelke
Moira Wilson
Mildred Manty

Legislation
Marjorie Okinaka
Elizabeth Stillman
Evelyn Young
Fumiyo Yamanaka
Rosie Chang
Marjorie Wagner
Alison MacBride
Loretta Schuler
Eleanor Apo
Mae Lockmiller
Ethel Edgar
Edyth Collins

Library
Sister M. Petra
Betty Ikeda
Olga Froien
Loretta Schuler
Myra Ching
Wilhelmina Beckstrom

Margaret Jones Memorial Fund Committee
Margaret Bennett
Lily Higashi
Chitose Kanuha
Leona Adam
Gloria Foster
Audrey Berrington
Margaret Barnett
Helen Hetrick

Membership Committee
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Judy Fujimoto
Ruth Thurman
Bessie Awakuni
Jean Inouye
Harriet Tanabe
Lois Schneidoff
Natsumi Hodson
Judith Tateishi
Jean McLaren
Sister Miriam Dionice
Mamie Murakami
Eleanor Fern
Ethel Edgar
Mae Lockmiller
Florence Shibano
Ruth Thurman
Joyce Fujioka
Betty Sora
Hilda Akana
Miriam Kemmerer

Nursing Information Committee
Jean Grippin
Sister Frances Cabrini
Agnes Branco
Rosie Chang
Hazel Kim
Flora Ozaki
Mildred Kim
Katsuko Enoki

Oahu Health Council
Loretta Schuler

Professional Advancement
Yasuko Imanaka
Katherine Kanetoku
Tomiko Hashimoto
Hazel Kim
Virginia Jones
Patricia Waterman
Sister Vera
Margaret Barnett
Hazel Flagg
Elizabeth McCall
Hazel Kim
Virginia Jones
Jane Sawaguchi

Program Arrangements Committee
Eleanor Fern
Haruyo Yoshioka
Eunice Graham
Ine Higa
Hazel Kim
Leona Rubbelke
Susan Reichert
Mae Ikeda
Colene Wong
Takeko Hamasu
Faye Hayashi
Sister Frances Cabrini
Rose Jenkins
Mae Tokunaga

Holdover members appear in *bold* type.

Officers and Directors 1959-1960

OFFICERS	TERM EXPIRES
President: Sister Maureen	1960
1st Vice-President: Elizabeth McCall	1961
2nd Vice-President: Sister M. Laurine	1960
Secretary: Hazel Kim	1961
Treasurer: Clifford Burroughs	1960

DIRECTORS	
Hawaii: Eunice Graham	1961
Kauai: Thelma Hensley	1962
Maui: Grace Lusby	1960
Oahu: Lily Tomita	1961
At Large: Margaret Barnett	1960
Fumie Uratani	1962

SECTION CHAIRMEN	
EACT: Susan Reichert	1960
GD: May Lockmiller	1960
OH: Eileen MacHenry	1960
INSA: Margaret Kleinkopf	1960
PD: Elsie Rogozenski	1960
PH: Helen Frederick	1960
SP. GR: Helen Awaya	1960

HNA Convention Sets Goals for 1960

More than 400 hospital nurses, administrators, educators, public health nurses, industrial nurses, private duty nurses, and office nurses representing the four districts of the State of Hawaii attended the twenty-eighth annual convention of HNA which was held in the auditorium of the Mabel Smyth Memorial Building, Honolulu, October 15 to 17. The theme of the conference, "Nursing Meets Personality Needs," was considered in terms of local and national progress and issues.

Dr. William E. Mayer, Psychiatrist in charge of the Hawaii County Mental Health Service, was the principal speaker. He emphasized that the personality and attitudes of the nurse particularly qualify her for her profession.

Following his talk the next day, a panel discussion included many questions from the audience on the mental health needs of nurses and patients.

The program included:

Invocation

The Hawaii Nurses' Convention got off to a good start with an impressive invocation, devotional, and memorial service under the direction of Reverend Abraham Akaka, Pastor of Kawaiahao Church.

Approximately sixty students of the St. Francis Hospital School of Nursing Glee Club sang appropriate classical selections which set the tempo of dignity, challenge, and enthusiasm for an inspiring convention.

The President's Address

Sister Maureen, President of Hawaii Nurses' Association, in her opening address challenged the members' thinking by stating: "In looking forward to scan the horizons opening before us as a profession, one of our major responsibilities is to promote research. The ANA is contemplating a public fund drive to increase the finances of the American Nurses' Foundation. The public would react more favorably if the profession itself could show that its own members have been generous in their support. There is a need to develop nursing leaders. Young graduates whose enthusiasm will be interpreted as a stimulus to the experience of older members need to be recruited to participate as active members in our organization. This balance of the enthusiasm of youth with the experience of age is essential if we are to utilize to the fullest the God-given gifts of our members."

The President also reported on the actions taken by the ANA Board: 1. ANA and the American Medical Association met in Atlantic City to establish a liaison committee to augment and implement actions in mutual concern. Further meetings are planned. 2. ANA and NLN will meet again to explore future possibilities for a single organization in order to carry out the mandate of the 1958 ANA delegates in convention. 3. A civilian defense workshop is under consideration with ANA participating. 4. The ANA Board has gone on record as favoring legislation to guarantee equal pay for equal work, whether done by men or women.

Session

Personality Needs in a Crisis Profession

Dr. William E. Mayer, psychiatrist in charge of Hawaii County's Mental Health Service in Hilo, spoke to an overflowing audience on "Personality Needs in a Crisis Profession." He discussed mental health concepts which are often overlooked in nursing—how the patient feels, how he reacts to his illness, and his emotional needs and anxieties. All these emotional needs are important to the patient's welfare and to his progress. Professional nurses should be mindful that they do not just perform technical procedures; they must serve the patient's psychological needs too. Professional nurses should be more aware of the anxieties which people have.

Dr. Mayer touched on the pressures which the professional nurse has as a result of her contacts with the patient, nursing supervisors, physicians, x-ray, and laboratory technicians, and how they affect her relationships with patients and coworkers.

Some of the questions he put to his captivated audience were: (1) Are you as "good" to the venereal disease patient, the "cantankerous" senile, and the patient with tuberculosis as you are to others? (2) How do you react to a pregnant woman who has fears and anxieties? (3) Do you pass judgments on patients who appear overly anxious or demanding? (4) How does the patient's social status affect your work with him?

More and more professional nurses need to realize that the patient's emotional problems, his needs and how you deal with them, are the crux of the medical and nursing professions.

Latest Trends in Psychiatric Therapy

Captain John F. McMullen, M.C., of Tripler Hospital spoke on the "Latest Trends in Psychiatric Therapy."

Captain McMullen emphasized the fact that mental illness was still the number one health problem. Too, that the shortage of personnel and cost of care still poses serious problems in the United States.

Social or milieu therapy, the key point in treatment, is used in both institutions and day care centers, which are becoming more numerous.

Role Playing: the Past and Present in Psychiatric Nursing

Honolulu's three schools of nursing were represented by a role-playing group which portrayed the custodial care of the past compared to the current practices in helping the mentally ill patients in psychiatric hospitals.

The students showed much insight in the application of their learning experiences in both theory and practice of what constitutes mental health rehabilitation practices today.

The audience was pleased to see the progress in psychiatric nursing and felt that the students had captured the significance of the need for helping their patients.

Miss Eleanor Cranch, Instructor, University of Hawaii College of Nursing, and Miss Loretta Schuler, Educational Director at the State Psychiatric Hospital, guided the students in their originality and planning for the role playing.

Looking at Ourselves

The panel on "Looking at Ourselves" was stimulated by the discussion of questions submitted by members of Hawaii Nurses' Association arising from Dr. Mayer's talk. The listeners were given a challenge to become more aware of themselves and were given methods of introspection.

Dr. George F. Harding, Assistant Director of the Division of Mental Health, acted as moderator for the panel. The participating members were: Mrs. Yukie Gross, Assistant Professor, and Miss Susan Reichert, Instructor, at the University of Hawaii College of Nursing, Mrs. Wilma Amalu, Supervisor of The Queen's Hospital Outpatient Department, and Dr. Robert Dimler, pediatrician, from the Kailua Medical Group.

The panel discussed the role of the psychiatrist in nursing education today. The nurse's role in handling the patient's feelings which are related to illness and recovery. The nurse's role in becoming more aware of and more alert to her own reactions. The nurse's role in acquiring the ability to use critical thinking, especially in her relationships with doctors.

Understanding Patients Who Present Problems

"Effective Communication in Nursing" was discussed by Mr. Alex Tokimoto, Managing Director of Dale Carnegie Training Institute, at the Public Health Nurses' Section.

The points which he discussed and which were re-enforced by a short film were: support ideas with a witness, understate and "over-prove" points, qualify statements, make tests testify, show externally inward beliefs, and use only strong links in testifying.

Social Events

On Friday evening, October 16, the members and their guests turned out for a luau at Tripler Officers' Club.

Col. Hubert W. Miller, Director of Medical Services at Hickam Air Force Base challenged his audience as to what they might expect when they go space travelling. He told of the research being done here and on the Mainland. An amusing film which brought out some of the more significant points was shown in conjunction with the talk.

REVISED BYLAWS
Hawaii Nurses Association Bylaws

Please clip these revisions and paste or staple them to your present copies.

ARTICLE I—Title

Section 1. The name of this association shall be the Hawaii Nurses Association.

ARTICLE III—Membership

Section 8. Same

Add Section 9. Honorary membership may be conferred by a unanimous vote at any annual convention on members who have rendered distinguished service to the nursing profession over a period of twenty-five (25) years through outstanding leadership in the Nurses Association.

ARTICLE X—Board of Directors

Section 2. The regular meeting of the board of directors shall be held within the month preceding and again within the two months' period following each annual convention. The regular meetings of the board may also be held at such time and place as shall from time to time be determined by action of the board.

ARTICLE XIII—Sections

Section 3. Section officers shall be elected at an annual meeting which shall be held either at the time and place of the annual convention or preceding the convention, such slate of officers to be presented at the House of Delegates. Officers elected prior to the annual convention will not take office until after the convention.

DON'T BE A DELINQUENT IN 1960

Under Chapter 67, Revised Laws of Hawaii as amended 1959, each nursing license must be renewed on or before June 30 annually. Otherwise (unless inactive status is requested in writing) a late registration penalty of $5.00 will be charged. Keep the Board informed of address change to insure proper mailing.

REVISED RULES

Educational Administrators, Consultants, and Teachers Section, Hawaii

October, 1959

RULE 1—NAME

The name of this section shall be the Educational Administrators, Consultants, and Teachers Section of the Hawaii Nurses Association.

RULE 2—Objectives

The object of this section shall be:

Section a. To promote better nursing care of the public through consideration of problems related to the practice of nurses in the field of nursing education.

Section b. To support and promote the aims and program of the Hawaii Nurses Association.

RULE 3—Functions

The functions of the section shall include the following:

Section a. To define qualifications for membership which are consistent with the general membership requirements of the HNA.

Section b. To make rules for the government of the section provided these shall in no way conflict with the by-laws of the HNA, and shall be approved by the board of directors.

Section c. To cooperate with and assist the ANA section in defining and interpreting the functons, standards, and qualifications for practice of the educational administrators, consultants, and teachers, and others as recommended by the ANA Section Executive Committee.

Section d. To initiate studies or experiments for the improvement of practice within the field in relation to the overall purpose of the HNA, and the American Nurses' Association.

Section e. To study the general welfare and economic needs of the members and develop desirable standards of employment.

Section f. To organize subunits within the section, on request, in order that groups which have like interests shall have the opportunity of meeting to consider the economic security program separately from other groups in the same section whose economic interests might be somewhat different. The subunits shall have the privilege of reporting directly to the board of directors of the HNA.

Section g. To represent the interests of its members in meetings of the association.

Section h. To develop relationships with allied professional groups for conferences or committee work related to the objectives of the HNA.

Section i. To conduct programs of special interest to the members of the section and to participate with other sections that have similar interests.

Section j. To organize upon request, branches within the section for particular areas of practice, and conference groups between sections for special interests.

Section k. To develop and actively promote a program for intergroup relations within the section.

Section l. To plan a program of work and prepare an appropriate budget, annually, for presentation to the Committee on Finance of the HNA.

Section m. To make pronouncements in the name of the section, provided these pronouncements are not in opposition to the policies accepted by the HNA, and do not purport to represent the policies of the association as a whole.

Section n. To interpret all policies accepted by the HNA that affect the section and to publish these policies in the name of the section.

Section o. (1) To keep open direct channels of communication with the Educational Administrators, Consultants and Teachers Section of the American Nurses' Association, and to submit simultaneously copies of such communication to the Executive Secretary at state and ANA headquarters.

(2) To keep open direct channels of communication with the Educational Administrators, Consultants, and Teachers Sections of district associations, and to submit simultaneously copies of such communications to the presidents and executive secretaries (or elected secretaries) of the district associations.

Section p. To elect delegates to biennial conventions and special meetings of the ANA in conformity with Article X, Section 2 (a) of the By-Laws of the ANA, and Article IX, Section 7 of the HNA.*

RULE 4—Membership

Graduate registered professional nurses, members of the HNA who hold any position concerned with nursing education, or who held such a position at the time of their retirement, also other nurses whose interest is in the field of nursing education, are eligible for membership in the section.

RULE 5—Officers

Section a. The officers of this section shall be a chairman, a first vice chairman, a second vice chairman, and a secretary, each of whom shall be actively engaged in nursing education at the time of election.

Section b. The regular term for all officers shall commence at the adjournment of the annual meeting at which they are elected.

RULE 6—Duties of Officers

Section a. The chairman, (1) shall serve as a member of the Board of Directors of the SNA, preside at all meetings of the section, the executive committee and the advisory forum, and be an ex-officio member of all committees except the committee on nominations.

(2) shall represent the section on the Advisory Forum of the Educational Administrators, Consultants, and Teachers Section of the American Nurses' Association.

(3) shall be authorized to appoint any special committee necessary to further the work of the section, subject to the approval of the Executive Committee.

Section b. The first vice chairman shall perform the duties of the chairman in her absence, shall become the chairman in case of vacancy in that office, and shall assume such duties as may be delegated to her by the Executive Committee.

Section c. The second vice chairman shall become the first vice chairman in case of a vacancy in that office and shall assume such duties as may be delegated to her by the Executive Committee.

Section d. The secretary shall keep the minutes of all meetings, a copy of which shal be furnished the secretary of the HNA within two weeks following each meeting. The secretary shall write to the chairman of the district sections for Educational Administrators, Consultants, and Teachers prior to the annual convention asking for suggestions for committee members for the work of the state section.

Section e. All officers will make available to their successors all pertinent section material within two weeks after termination of office.

RULE 7—Executive Committee

Section a. There shall be an Executive Committee which shall consist of the chairman, the first vice chairman, the second vice chairman, the secretary, and two members-at-large elected as hereinafter provided. (Rule 13)

Section b. Regular meetings of the Executive Committee shall be held immediately preceding and immediately following the annual convention of the HNA at the place where such convention is held, and at such other time as shall be determined by the Executive Committee.

Section c. Special meetings of the Executive Committee may be called by the chairman on five days notice to each member either personally or by mail or by telegraph and shall be called by the chairman in like manner upon the request of not less than three members of the Executive Committee. Special meetings shall be held at such time and place as may be specified in the notice.

Section d. In intervals between regular meetings of the Executive Committee, the chairman of the section may refer and submit to the members of the Executive Committee definite questions relating to the affairs of the section which

require immediate action. The result of such referendum shall control the action of the Executive Committee and shall be reported at the next meeting of the committee and recorded in the minutes.

Section e. Absence without good cause from three meetings of the Executive Committee shall constitute a resignation from this committee. Such vacancies shall be filled as hereinafter provided.

Section f. Absence of the section chairman from two meetings of the Board of Directors of the SNA, without good cause, shall constitute a resignation from this committee. Such a vacancy shall be filled as previously provided.

Section g. Absences without good cause shall be determined by the Executive Committee.

RULE 8—Duties of the Executive Committee

The Executive Committee shall:

Section a. Appoint all standing committees except the committee on nominations and approve the appointment of all special committees.

Section b. Prepare the annual budget and provide for the expenditure of funds.

Section c. Review report of expenditures periodically.

Section d. Implement all functions of the section as set forth in these rules.

Section e. Consider and act upon requests for organization of branches, and subunits within the section and conference groups between the sections for special interests.

Section f. Fill any vacancies occurring on the committee on nominations and on the Executive Committee except that of chairman and first vice chairman.

Section g. Be responsible for guidance of the section in the achievement of its objectives and the coordination of its activities.

Section h. Transact the general business of the section in the interim between regular meetings.

Section i. Act in an advisory capacity to districts in all section problems referred to this section of the HNA.

Section j. Develop relationships with other sections of the HNA, and with departments of the Hawaii League for Nursing for conferences or committee work relating to mutual problems.

Section k. Receive and review reports of section committees, branches, and conference groups and make appropriate recommendations to the Board of Directors of the SNA.

Section l. Approve minutes of previous Annual Meeting immediately following that Annual Meeting.

RULE 9—Committees

Section a. Standing committees shall be composed of at least three members of the section, and shall assume such duties as shall be specified in these rules, and such other duties as may be assigned to them by the executive committee. Only active members shall be chairmen of standing committees.

Section b. The following standing committees (with the exception of three members of the Committee on Nominations who shall be elected as hereinafter provided), shall be appointed after each convention and shall serve until their respective successors are appointed: (1) Committee on Functions, Standards, and Qualifications for Practice. (2) Committee on Nominations (elected). (3) Committee on Program. (4) Committee on Rules.

Section c. The Committee on Functions, Standards, and Qualifications for Practice shall cooperate and assist the corresponding committee of the EACT section of the ANA to define and interpret the functions, standards, and qualifications of practice within the various fields of nursing education. It shall guide and direct the work of the corresponding committee of the district sections for educational administrators, consultants, and teachers. This committee shall be composed of active members only.

Section d. The Committee on Nominations shall consist of three active members of the section who shall be elected as hereinafter provided. This committee shall prepare a ticket for the section for each (annual) convention. This ticket shall consist of the names of two or more members of the section, who have consented to serve if elected, for each office to be filled, including Executive Committee members-at-large and members of the Committee on Nominations. No nominee shall appear on the ballot if election could result in concurrent membership on the Board of Directors or Committee on Nominations of the SNA or any other state nursing organization or on the steering committee of the divisions of the State League for Nursing.

Prior to the preparation of such a ticket, and at least six months before the scheduled date for the (annual) convention, the chairman of the Committee on Nominations shall request from the district sections of Educational Administrators, Consultants and Teachers a list of names of persons qualified to fill vacancies in these offices.

In preparation of the ticket, the Committee on Nominations shall give consideration to: (1) Qualifications of candidates. (2) Distribution in special fields of interest. (3) Geographic distribution. (4) Names suggested by the largest number of districts.

The Committee on Nominations shall send the ticket of the EACT Section to the headquarters of the Hawaii SNA in such time that the ticket can be sent to the district nurses' association at the same time that the ticket of the Hawaii SNA is sent to them.

The ticket shall be presented to the members of the section at its first business meeting during the (annual) convention, at which time nominations from the floor may be added.

Section e. The Committee on Program shall receive suggestions from districts for programs and shall prepare programs for the regular meetings of the section. It shall submit the section's program for the annual meeting to the chairman of the committee on program of the HNA at a time designated by the chairman of the Committee on Program of the HNA.

Section f. The Committee on Rules shall review the present rules, receive and consider proposed amendments and make recommendations to the executive committee. This committee shall upon request of a district section review district rules and make recommendations to district sections.

RULE 10—Subunits

Section a. Subunits shall be organized on request within the section in order that groups which have like interests shall have the opportunity of meeting to consider the Economic Security Program separately from other groups in the same section whose economic interests might be somewhat different. Such subunits shall have the privilege of reporting directly to the Board of Directors of the HNA. The functions of a subunit shall be to: (1) Adopt employment standards for its members. (2) Cooperate with the HNA Board of Directors in the implementation of these standards. (3) Serve in an advisory capacity in all matters affecting the economic welfare of its members.

The officers of a subunit shall be a chairman and a secretary, each of whom shall be actively engaged in nursing education at the time of election and who shall be elected annually by members of the subunit.

Section b. A subunit Committee on Employment Conditions, composed of the chairman of the subunit and at least two active elected members of the subunit, shall be formed as soon as subunits are established. This committee: (1) Shall prepare tentative employment standards, or revise existing standards. (2) Shall present standards to the subunit membership for consideration and adoption. (3) May transact business of an urgent nature, pertaining to standards, between subunit meetings. All transactions of this committee shall be reported in full at the next regularly scheduled meeting of the subunit.

RULE 11—Advisory Forum

Section a. The Executive Committee of this section and the chairman of the district sections for Educational Administrators, Consultants, and Teachers shall constitute an advisory forum to consider and promote the interests of the Educational Administrators, Consultants, and Teachers Section of the HNA.

Section b. In the absence of the HNA, chairman, either the first vice chairman, second vice chairman, secretary, or some other active member of the section, appointed by the district chairman, shall act in her capacity.

Section c. Meetings of the advisory forum shall be held in connection with each annual convention as provided for by the committee on program of the Educational Administrators, Consultants, and Teachers Section of the HNA.

RULE 12—Voting Body

The voting body at any meeting of the Educational Administrators, Consultants, and Teachers Section shall consist of the active members of the section who are in attendance and have submitted identification as active members of the section.

RULE 13—Elections

Section a. A chairman, a second vice chairman, and one member-at-large of the Executive Committee shall be elected in the even years to serve for two years or until their successors have been elected. A first vice-chairman, a secretary, and one member-at-large of the Executive Committee shall be elected in the odd years to serve for two years or until their successors have been elected. Three members of the Committee on Nominations shall be elected to serve until their successors have been elected. Election of officers and voting on amendments shall be upon identification of voters as members of the section.

Section b. Election shall be by ballot at the time and place provided for the election by the HNA.

Section c. A plurality vote of the members of the section present, entitled to vote and voting, shall constitute an election.

Section d. At the first business meeting of the section at the annual convention, the chairman shall appoint tellers.

Section e. No member shall serve more than two consecutive terms in the same office; the period of consecutive service on the Executive Committee shall not exceed eight years. A member who has served more than one-half terms shall be deemed to have served a full term.

RULE 14—Meeting

Section a. This section shall meet at such time and place as shall be recommended by the section, and approved by the Executive Committee of the section.

Section b. Section officers shall be elected at an annual meeting which shall be held either at the time and place of the annual convention or preceding the convention. Such slate of officers to be presented at the house of delegates. Officers elected prior to the annual convention will not take office until after the convention.

Section c. Business meetings shall be open to members of the section and guests, unless otherwise voted. Nonmembers, if admitted, may have voice but no vote.

RULE 15—Order of Business

The order of business at annual meetings shall be:

(1) Roll call
(2) Report of Committee on Nominations
  (a) Completion of Ticket
  (b) Introduction of Candidates
(3) Appointment of Tellers
(4) Report of the Chairman of the EACT Section of the HNA
(5) Reports of other standing committees:
  (a) Report of Committee on Functions, Standards and Qualifications for Practice
  (b) Report of Committee on Program
  (c) Report of Committee on Rules
(6) Reports of special committees
(7) Reports of branches and conference groups
(8) Reports of chairmen of the Educational Administrators, Consultants, and Teachers sections of district nurses' association
(9) Unfinished business
(10) New business
(11) Report of Tellers and introduction of new officers
(12) Reading of minutes for correction
(13) Adjournment

RULE 16—Quorum

Section a. A quorum at any meeting of the section shall consist of one officer, and members present, and entitled to vote and voting.

Section b. A quorum at any meeting of the Executive Committee shall consist of a majority of the members.

RULE 17—Amendments

Section a. These rules may be amended at any (annual or biennial) meeting by a two-thirds vote of the members present, entitled to vote and voting, provided the proposed amendments have been approved by the Board of Directors of the HNA and have been appended to the call of the meeting.

Section b. These rules may be amended without previous notice at any (annual) meeting by a 99 percent vote of the members present, entitled to vote and voting, and become effective after approval by the Board of Directors of the HNA.

Institutional Nursing Service Administrators Section October, 1959

RULE 1—Name

The name of this section shall be the Institutional Nursing Service Administrators Section of the Hawaii Nurses Association.

RULE 2—Membership

Section a. Members* of the Hawaii Nurses Association, holding any of the following positions in hospitals or similar institutions for the care of the sick, now or at the time of their retirement from all nursing practice are eligible for membership in this section: Administrators, directors, assistant or associate directors, supervisors and head nurses, whose responsibility in nursing service is administration.

Section b. Members* of the Hawaii Nurses Association, whose responsibility in nursing is consultation, research or teaching dealing with hospital nursing service, now or at the time of their retirement from all nursing practice are eligible for membership in this section (Employer not specified).

Section c. In those instances in which a change of position necessitates a change of section, such change in section membership should be effected within a reasonable time not to exceed three months.

RULE 3—Objectives

The objectives of this section shall be to:

Section a. Foster high standards of administrative nursing practice in hospitals and similar institutions.

Section b. Stimulate a greater awareness of the responsibility of individual members in the promotion of the welfare and development of nursing personnel.

Section c. Support and promote the aims and program of the Hawaii Nurses Association.

RULE 4—Functions

The functions of the section shall include the following:

Section a. To define the qualifications for membership which are consistent with the general membership requirements of the Hawaii Nurses Association.

Section b. To make rules for its government, provided these rules shall in no way conflict with the bylaws of the Hawaii Nurses Association; to submit them to the SNA Committee on Constitutions and Bylaws for review, to the SNA Board of Directors for approval, and to the section membership at their (annual) convention.

Section c. To cooperate with and assist the ANA section in defining and interpreting the functions, standards, and qualifications for practice for the section members.

Section d. To initiate studies or experiments for the improvement of practice of the members in relation to the over-all purpose of the Hawaii Nurses Association and the American Nurses' Association.

Section e. To study the economic needs and general welfare of the members and develop desirable standards of employment and to promote equal opportunities for all members of the section regardless of race, creed or national origin.

Section f. To promote the organization of subunits within the section in order that groups which have like interests shall have the opportunity of meeting to consider the economic security program separately from other groups in the same section whose economic interests might be somewhat different. The subunits shall have the privilege of reporting

* Unless otherwise specified, members shall be interpreted to include both active and associate.

directly to the Board of Directors of the Hawaii Nurses Association.

Section g. To represent the interests of its members in meetings of the association.

Section h. To develop relationships with allied professional groups for conferences or committee work related to the objectives of the Hawaii Nurses Association.

Section i. To conduct programs of special interest to the members of the section, and participate with other sections that have similar interests.

Section j. To organize branches for particular areas of practice, and/or conference groups on request for special interests between sections.

Section k. To plan a program of work and prepare an appropriate budget annually, for presentation to the committee on finance of the Hawaii Nurses Association.

Section l. To make pronouncements in the name of the section, provided these pronouncements are not in opposition to the policies accepted by the Hawaii Nurses Association and do not purport to represent the policies of the association as a whole.

Section m. To interpret all policies accepted by the Hawaii Nurses Association that affect the section and to publish these interpretations in the name of the section.

Section n. (1) To keep open direct channels of communication with the Institutional Nursing Service Administrators Section of the American Nurses' Association, with information going simultaneously to the executive secretaries at SNA and ANA headquarters.

(2) To keep open direct channels of communication with the Institutional Nursing Service Administrators Section of district associations, with information going simultaneously to the presidents and elected or executive secretaries of the district associations.

Section o. To elect delegates to biennial conventions and special meetings of the American Nurses' Association in conformity with Article X, Section 2 (a) of the American Nurses' Association Bylaws, and Article IX, Section 2 (b) of the Hawaii Nurses Association Bylaws.*

Section p. To submit a written report of the section activities to the Board of Directors of the Hawaii Nurses Association upon request and to the association at their (annual) convention.

RULE 5—Fund Raising

This section may engage in fund raising provided that plans be submitted to and approved by the Board of Directors of the Hawaii Nurses Association.

RULE 6—Officers

Section a. The officers of this section shall be a chairman, a first vice-chairman, and a secretary, each of whom shall be active members currently engaged in any of the aforementioned positions.

Section b. The regular term for all officers shall commence at the adjournment of the meeting at which they are elected.

RULE 7—Duties of Officers

Section a. The chairman: (1) Shall preside at all meetings of the section, the executive committee and the Advisory Forum* and be an ex officio member of all committees except the committee on nominations. (2) Shall be authorized to appoint any special committee necessary to further the work of the section, subject to the approval of the executive committee.

Section b. In the absence of the chairman the first vice-chairman shall perform the duties of the chairman* and shall become the chairman in case of a vacancy in that office and shall assume such duties as may be delegated by the executive committee.

Section d. The secretary shall keep the minutes of all meetings, a copy of which shall be furnished the secretary of the Hawaii Nurses Association within two weeks following each meeting.

The secretary shall write to the chairman of the district sections for institutional nursing service administrators prior to the (annual) convention asking for suggestions for committee members for the work of the state section.

* These delegates may be elected from names suggested by district sections, provided such procedure conforms with the Hawaii Nurses Association Bylaws.

Section d. All officers shall deliver to their successors all pertinent section material within two weeks after termination of office.

RULES 8—Executive Committee

Section a. There shall be an executive committee which shall consist of the chairman, the first vice-chairman, the secretary, and two members-at-large elected as hereinafter provided. (Rule 14)

Section b. Regular meetings of the executive committee shall be held immediately preceding and immediately following the (annual) convention of the Hawaii Nurses Association, at the place where such convention is held, and at such other times as shall be determined by the executive committee.

Section c. Special meetings of the executive committee may be called by the chairman on 7 days notice to each member either personally or by mail or by telegraph and shall be called by the chairman in like manner upon the written request of not less than 10 members of the section or 3 members of the executive committee. Special meetings shall be held at such time and place as may be specified in the notice.

Section d. In intervals between regular meetings of the executive committee, the chairman of the section may refer and submit to the members of the executive committee definite questions relating to the affairs of the section which require immediate action. The result of such referendum shall control the action of the executive committee.

Section e. Absence without good cause from 3 meetings of the executive committee shall constitute a resignation from this committee. Such vacancies shall be filled as hereinafter provided.

RULE 9—Duties of Executive Committee

The Executive Committee shall:

Section a. Appoint all standing committees except the committee on nominations, and approve the appointment of all special committees.

Section b. Prepare the annual budget and provide for the expenditure of funds.

Section c. Review report of expenditures periodically.

Section d. Implement the functions of the section as set forth in these rules.

Section e. Consider and act upon requests for organization of branches and subunits within the section and/or conference groups for special interests between sections.

Section f. Fill any vacancies occurring on the committee on nominations and on the executive committee except that of chairman and first vice-chairman. In the event of a vacancy in the office of secretary, the executive committee shall fill the vacancy from the members of the executive committee. In the event of a vacancy in the office of member-at-large, the executive committee shall appoint the candidate who received the next highest number of votes for this office at the previous (annual) convention meeting of the section.

Section g. Be responsible for guidance of the section in the achievement of its objectives and the coordination of its activities.

Section h. Transact the general business of the section in the interim between regular meetings.

Section i. Act in an advisory capacity to districts in all section problems referred to this section of the Hawaii Nurses Association.

Section j. Develop relationships with other sections of the Hawaii Nurses Association and with departments in the Hawaii League for Nursing for conferences or committee work relating to mutual problems.

Section k. Receive and review reports of branches, conference groups and committees.

RULE 10—Committees

Section a. Standing committees shall be composed of at least three members of the section, and shall assume such duties as shall be specified in these rules, and such other duties as may be assigned to them by the executive committee. Only active members currently engaged in nursing practice shall be chairman of standing committees.

Section b. The following standing committees (with the exception of three members of the committee on nominations

who shall be elected as hereinafter provided) shall be appointed after each (annual) convention and shall serve until their respective successors are appointed: (1) Committee on Functions, Standards, and Qualifications for Practice. (2) Committee on Nominations (elected). (3) Committee on Program. (4) Committee on Rules.

Section c. The Committee on Functions, Standards, and Qualifications for Practice shall cooperate and assist the corresponding committee on the Institutional Nursing Service Administrators Section of the American Nurses' Association to define and interpret the functions, standards, and qualifications for practice within the field of institutional nursing service administration. It shall guide and direct the work of the corresponding committees of the district sections for institutional nursing service administrators. This committee shall be composed of two representatives of each major level of administrative responsibility.

Section d. The Committee on Nominations shall consist of three active members of the section. This committee shall prepare a ticket for each convention. The names of candidates who are members of the section, have consented to serve, and are qualified to fill the respective vacancies shall comprise the ticket as follows: (1) Two or more candiates for *each* of the following offices: chairman, first vice-chairman, and secretary. (2) Two or more candidates for each member-at-large of the executive committee. (3) Six or more candidates for the committee on nominations.

Prior to the preparation of such a ticket, and at least six months before the scheduled date for the (annual) convention meeting, the chairman of the committee on nominations shall request from the district sections of institutional nursing service administrators, a list of names of persons qualified to fill vacancies in these offices.

In the preparation of the ticket, the committee on nominations shall give consideration to: (1) Candidates qualified to fill the office. (2) Those who are representative of the varied interests in nursing service administration and of various areas of the state insofar as possible. (3) Names suggested by the largest number of institutional nursing service administrators sections of district nurses' associations. (4) Various positions within nursing service administration.

The Committee on Nominations shall send the ticket of the Institutional Nursing Service Administrators Section to the headquarters of the Hawaii Nurses Association in such time that the ticket can be sent to the District Nurses Associations at the same time as the ticket of the Hawaii Nurses Association is sent to them.

The ticket shall be presented to the members of the section at its first business meeting during the (annual) convention, meeting at which time nominations from the floor may be added.

Section e. The Committee on Program shall receive suggestions from the districts for programs and shall prepare the programs for the regular meetings of the section. It shall submit the section of program for the convention meeting to the chairman of the Committee on Convention Program of the Hawaii Nurses Association at a time designated by that chairman.

Section f. The Committee on Rules shall: (1) Receive and act upon all proposed amendments to these rules and shall submit a report of proposed revisions, with recommendations to the executive committee. Proposed revisions shall then be submitted to the Committee on Constitution and Bylaws of Hawaii Nurses Associaion and to the Committee on Rules of the American Nurses' Association INSA Section (optional) for review; to the Board of Directors of the Hawaii Nurses Association for approval; and to the section members at their (annual) meeting. (2) Review district rules and their amendments and make recommendations to district sections.

RULE 13—Voting Body

The voting body at any meeting of the Institutional Nursing Service Administrators Section shall consist of the active members of the section who are in attendance and have submitted identification as active members of the section.

RULE 14—Elections

Section a. A chairman and one member-at-large of the executive committee shall be elected in the even years to serve for 2 years or until their successors have been elected. A first vice-chairman, a secretary and one member-at-large of the executive committee shall be elected in the odd years to serve for 2 years or until their successors have been elected. Three members of the committee on nominations shall be elected to serve until their successors have been elected. The candidate for the committee on nominations receiving the highest number of votes shall be declared chairman of the committee. Elections and voting on amendments shall be upon identification of voters as active members of the section.

Section b. Election shall be by ballot at the time and place provided for election by the Hawaii Nurses Association.

Section c. The ticket shall be presented to the members of the section at the first business meeting during the (annual) meeting at which time nominations may be added from the floor.

Section d. A plurality vote of the members of the section present, entitled to vote and voting, shall constitute an election.

Section e. At the first business meeting of the section at the (annual) convention, the chairman shall appoint tellers.

Section f. No member shall serve more than two consecutive terms in the same office. A member who has served more than half a term in any office shall be deemed to have served a term.

RULE 15—Meetings

Section a. This section shall meet at such times and places as recommended by the section, and approved by the executive committee of the section.

Section b. The (annual) meetings shall be held at the time and place of the (annual) convention of the Hawaii Nurses Association. Business meetings shall be open to members of the section only, unless otherwise noted.

RULE 16—Order of Business

The order of business at (annual) meetings shall be:

(1) Roll call by districts
(2) Reading of minutes of previous meeting
(3) Report of Committee on Nominations
  (a) Completion of ticket
  (b) Introduction of candidates
(4) Report of the Chairman of the Institutional Nursing Service Administrators Section of the Hawaii Nurses Association.
(5) Reports of other standing committees
  (a) Report of Committee on Functions, Standards, and Qualifications for Practice
  (b) Report of Committee on Program
  (c) Report of Committee on Rules
(6) Reports of special committees
(7) Reports of branches and conference groups
(8) Reports of Chairmen of the Institutional Nursing Service Administrators Sections of district nurses' associations
(9) Unfinished business
(10) New business
(11) Report of tellers and introduction of new officers
(12) Reading of minutes for correction
(13) Adjournment

RULE 17—Quorum

Section a. A quorum at any meeting of the section shall consist of 2 officer(s) and members of the section representing not less than 3 district(s).

Section b. A quorum at any meeting of the executive committee shall consist of a majority of the members.

RULE 18—Amendments

Section a. These rules may be amended at any (annual) meeting by a two-thirds vote of the members present, entitled to vote and voting, provided the proposed amendments have been approved by the Board of Directors of the Hawaii Nurses Association and have been appended to the call to the meeting.

Section b. These rules may be amended without previous notice at any (annual) meeting by a 99 per cent vote of the members present, entitled to vote and voting, and become effective only after approval by the Board of Directors of the Hawaii Nurses Association.

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* Does not apply to meetings of the Board of Directors of the Hawaii Nurses Association.



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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

LYDIA C. MARTENS, *Editor* ETHEL NISHIBATA, *Associate Editor*

Postconvention Plans

The Hawaii Society of Medical Technologists' invitation for a postconvention in 1961 was extended to the House of Delegates of the American Society of Medical Technologists by Mrs. Louise Wulff, our delegate to the 1959 National Convention in Phoenix, Arizona. Our invitation was received and accepted with tremendous enthusiasm. Plans for the postconvention are therefore being formulated by Miss Ann Stegmaier and her committee.

In order to extend our warmest welcome the Society is launching a money-making project to defray expenses for rentals of hall for exhibits and seminar, souvenirs, refreshments, etc. Many projects were discussed at our October and November meetings. Some of the projects suggested by the members should be looked into further. These have been turned over to the finance committee to iron out the details. As our first project the selling of first aid kits will be undertaken. There will be two types of kits on sale, one selling at $1.95 and the other for $3.95.

All members are requested to do their best so that we can extend Hawaiian hospitality to the fullest.

Method for Culture of E. Histolytica Used at Territorial Hospital

A few years back, in 1956 to be exact, the laboratory was confronted with the problem of stretching its staff to conduct the necessary stool survey in an effort to reduce amebiasis at the Territorial Hospital. The number of fresh stools that could be examined by two technologists was limited not only by time and the eyesight of the technicians but by the practical problem of obtaining fresh specimens. As it worked out we were only able to do one stool per patient.

How to increase the efficiency of the staff and make one examination count for two? Culturing for ameba was the method finally decided upon and we ordered Difco's Endamoeba Medium. This is a liver infusion medium with proteose peptone, disodium phosphate, sodium chloride, and agar.

Using the medium as directed with a horse serum overlay and added rice starch, we cultured our first lot. There were some fifteen samples in our first trial, of which three or four had been found positive for E. histolytica on the direct examination. After repeated trial we discovered that the ameba were to be found at the bottom of the tube. The thrill of seeing our own home-grown ameba carried us through about two weeks of subsequent disappointments before we finally got methods of culturing and examining successfully established.

Here is our present method: Make up Difco's Endamoeba Medium according to directions, adjusting the pH of the water used to 7.0. Slant in screw cap tubes so that there is no butt. (In the tubes we use, about seven mls give a nice long slant with no butt.) Just before inoculating add 0.4 ml of horse serum, 1-6, Difco. This overlay is prepared as follows: Dissolve 1 gm of streptomycin in 10 ml sterile distilled water. Add 0.1 ml of this solution to 10 mls of the 1-6 horse serum. To this mixture add 3 drops of 3% NaOH. Store in refrigerator.

After adding the overlay sprinkle a large loopful of rice starch over the slant and into the overlay. We use Difco's Rice Powder, sterilizing it in a dry oven at 160° F for one hour. Inoculate the medium with feces about ½ cm in diameter, using an applicator stick to mix well with the overlay and streaking some of the material over the slant. Incubate upright at 37°C and examine at 24, 48, and 72 hours.

We get material for examination from the tube by using the small glass tubes from Baxter bottles as pipettes. They are just the right diameter and length. With one of these, get material from the bottom of the tube, place on a slide, and cover with a thin cover-slip. The whole area of the cover-slip should be examined. Often the amoeba are rounded, but after standing a few minutes they will begin to put out pseudo-pods.

Cultures vary from a scant few trophozoites to two or three per field. Unfortunately Dientamoeba fragilis and Endolimax nana grow as well as E. histolytica. To be sure of identification we run the following protozoan stain under the cover-slip: Place 200 ml H_2O in a 500 ml bottle and add 12.5 gms $NaSO_4$. Mix, then add 33.3 ml Glacial acetic acid. Add 200 mgs neutral red. Mix well and add 200 mg light green, SS yellowish. Shake well and filter. This excellent stain

colors the nucleus well but does not blot out the endoplasm.

You will not be able to see any difference between positive and negative cultures in the tubes and the amoeba will not grow in such quantities as to eliminate a thorough examination of the slide but for extra thoroughness, and to differentiate amoeba difficult to identify, this is the best method we know.

MARGUERITE BEATTY, HELEN HILL AND LOUISE WULFF

Methods Used in the Search for the Tubercle Bacillus in Sputum

Tuberculosis must be differentiated from lung abscess, bronchiectasis, fungus infection and, possibly other lung conditions. Abnormal lung conditions are being discovered earlier today than in former years. If the disease is tuberculosis, and if it is at an early stage, the tubercle bacillus is often difficult to detect. Hence the following three methods should be used: the direct microscopic examination, the culture, and the guinea pig inoculation.

For culture and guinea pig inoculation of sputum, the standard sodium hydroxide method of decontamination is used. Briefly, an equal amount of 4% sodium hydroxide is added to the sputum. This mixture is shaken for ten minutes in a shaker and then either incubated at 37°C for 20 minutes or left at room temperature for 30 minutes. It is neutralized with 5% hydrochloric acid, using brom-thymol blue as indicator. It is then centrifuged for 20 minutes at 2000 RPM. The supernatant fluid is discarded and the sediment is resuspended in 1 or 2 ml of sterile saline containing 50 units of penicillin per ml. Penicillin will reduce the number of contaminated cultures.

Culture: The suspension is cultured on at least two media: Wallenstein and Tarshis. Other good media are Lowenstein-Jensen, Petragnani, I. U. T. M. (International Union against Tuberculosis Medium), and A. T. S. (American Trudeau Society). Inoculate 2/10 ml of the suspension with a Pasteur pipette into a two-ounce prescription bottle. The bottle is left lying on its side for 24 hours, after which it is placed upright in a rack. The culture is then incubated at 37°C and read once a week until found to be positive. If negative, the incubation should be continued for a period of eight weeks. If there is appearance of growth within ten days, it is evidence that the organism is not tubercle bacillus.

The tubercle bacillus culture is typical. The color is variously described as tan, buff, or cream. The growth is elevated, rough, crumbly, and dry and does not discolor the culture medium. A smear made of the organisms from the culture should show clumps (cording) as well as some individual bacilli.

Guinea pig inoculation: With a Luerlok syringe, 1 ml of suspension is inoculated subcutaneously into the right groin which has been wet with alcohol or some other disinfectant. After the needle is withdrawn, the area is wet again with the disinfectant. The animal is inspected weekly for enlarged glands at the site of inoculation. If enlargement is found, the animal is autopsied for examination at the end of one month. If there is no enlargement at the end of one month, the animal is tested with 1/10 ml of 5% O.T. and then autopsied at the end of two months.

A a positive guinea pig will have infection of the glands at the site of inoculation, the iliac gland, and the spleen. Later the liver, the mediastinal, and the tracheobronchial glands and the lungs are also infected. A microscopic examination of the diseased tissues from the autopsied animal shows acid-fast organisms. (The culture of this material is a good method for isolating pure tubercle bacilli.)

Direct microscopic examination: If this reveals acid-fast organisms, it is a quick tentative confirmation of the physician's diagnosis of tuberculosis. However, this method is not as sensitive as the culture or guinea pig inoculation, and it does not differentiate the tubercle bacillus from other acid-fast organisms.

With slight or no modification, these methods are also applicable to other types of specimens. To obtain the maximum number of positives, consideration must be given to the kind of culture medium used, the pH of the inoculum, and the length of time of decontamination.

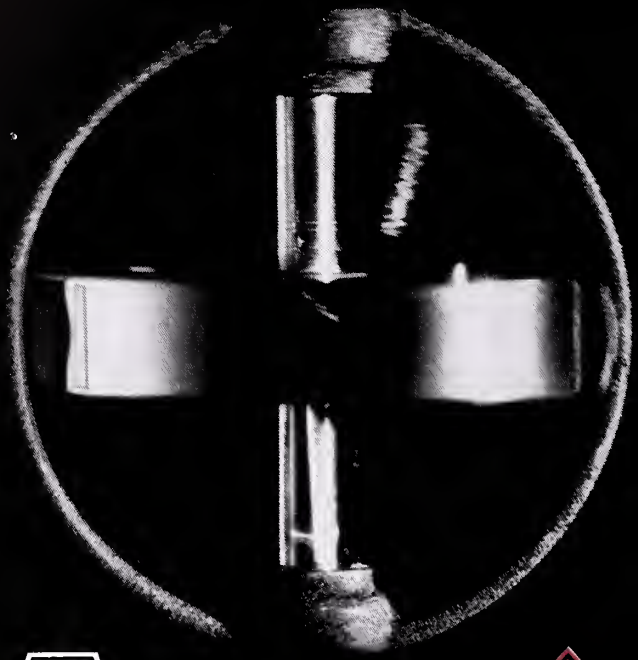
The tubercle bacillus can be distinguished from other acid-fast bacilli which cause pulmonary diseases and from acid-fast saprophytes by its cultural characteristics and by positive guinea pig inoculation.

Recently a new test was introduced, whereby the human tubercle bacillus is distinguished from all other acid-fast organisms so far encountered. This is the niacin test of Konno, modified by Runyon *et al.*

One ml of sterile saline is layered over the culture. After five minutes ½ ml of the fluid is removed to a test tube. To this an equal amount of 4% alcohol aniline and 10% aqueous solution of cyanogen bromide is added. If a yellow color develops in the solution, it indicates that niacin is present, which is only produced by the human tubercle bacillus in sufficient quantity to color such a solution.

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LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

HAWAII MEDICAL ASSOCIATION

(Continued from page 317)

sent to mainland medical societies inviting them to attend our 104th annual meeting and there have been some favorable replies.

FEDERAL MEDICAL CARE OF VETERANS

Dr. Nishigaya said that in line with the request made by the Council, he wrote the American Medical Association and urged that special congressional hearings be asked for on the matter of veterans' nonservice-connected disabilities. He read the answer received from Dr. Louis Orr who stated that "unfortunately it would be almost impossible for the Association to convince Congress that there is sufficient public interest to justify having more hearings at this time. . . ."

WOMAN'S AUXILIARY TRAVEL EXPENSES

A letter dated August 20 from the Advisory Committee of the Woman's Auxiliary explained that the Woman's Auxiliary wished to send a representative to the October, 1960, conference in Chicago. They feel this meeting is more important than the summer meeting and should be the one their representative attends in the future. The letter explained that the National Woman's Auxiliary had offered to match funds for this trip and they wish to draw the unspent portion of the allocation made them by the last House of Delegates for the purpose of sending representatives to the Mainland. It was noted that the representative is reimbursed only for her travel expenses. Dr. Allison felt that it might be better if the members of our own organization were sent to the Mainland rather than those of the Auxiliary inasmuch as we have limited funds. Dr. Burgess said he was opposed to giving them anything last year and he was still of the same mind. Dr. Cushnie asked if this were a precedent to come every year and was told it was not.

ACTION:

It was voted that the unspent portion of the $500.00 be given to the Woman's Auxiliary.

PHYSICIANS' FORUM

Dr. Nishigaya gave the background of the current project being sponsored by Honolulu County. He said that the "Advertiser" had first approached him but he felt that it should be on a trial basis in Honolulu and if it is worked well, it could then be worked out for the other islands. Honolulu County referred it to their Public Service Committee, which controls the subject and panel of doctors. Dr. Cushnie thought there should be more rigid control. Dr. Nishigaya said he felt that it was a sincere effort on the part of the newspaper to carry the ball on something that has been successful on the Mainland. Dr. Bergin said that if they were going to have a panel, they might get someone from the neighbor islands on it. Dr. Allison said that perhaps the idea is good but it has moved a little too rapidly. That the Health Education Committee is and has been doing things like this for many years and perhaps they should be tied in on this project. Dr. Nishigaya said that this item was put on the agenda for information only in order that the members from the other islands would know what it was all about. Dr. Allison thought that the Health Education Committee should have some liaison with all health education matters throughout the state. Dr. Bergin said that it is actually statewide when it comes out in the Honolulu papers. Since most neighbor island people subscribe to it Dr. Allison said that because the state is small, there should be an integrated effort on these things.

ACTION:

It was voted that all projects dealing with health education, regardless of the area, should be tied in with the state's Health Education Committee.

CHANGES IN MEMBERSHIP STATUS

The Council was advised that Honolulu County Medical Society had waived the dues of Dr. Teru Togasaki and had granted life membership to Drs. King Chee Chock, S. C. Culpepper, Marie Keim Faus, Min Hin Li, and Joseph Palma.

ACTION:

It was voted that the Hawaii Medical Association follow the action of the County and approve of the membership changes.

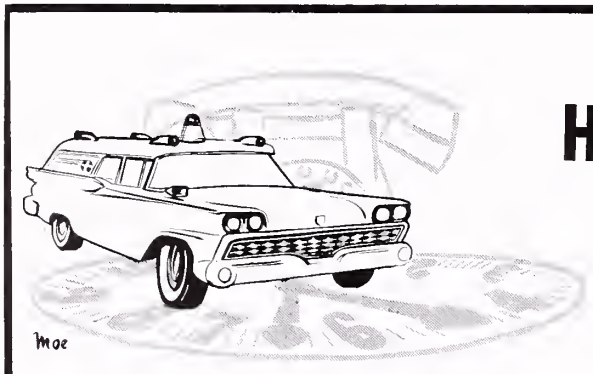
TREASURER'S REPORT

In the absence of Dr. Giles, no formal presentation was made. However, each member was given a verifax copy of the trial balance report for the first ten months of 1959.

OAHU HEALTH COUNCIL

Dr. Nishigaya explained that the Oahu Health Council is looking for new members for financial support. Dr. Arnold elaborated on their financial plight and explained that originally the Oahu Health Council was formed as an executive committee of the Honolulu Chamber of Commerce and they received income from individuals, business firms, and trust funds as well as from the Chamber of Commerce. He thought the services they render were very worthwhile functions in the community. The Council conducts a much more active program on health legislation than the Medical Association and

(Continued on page 340)



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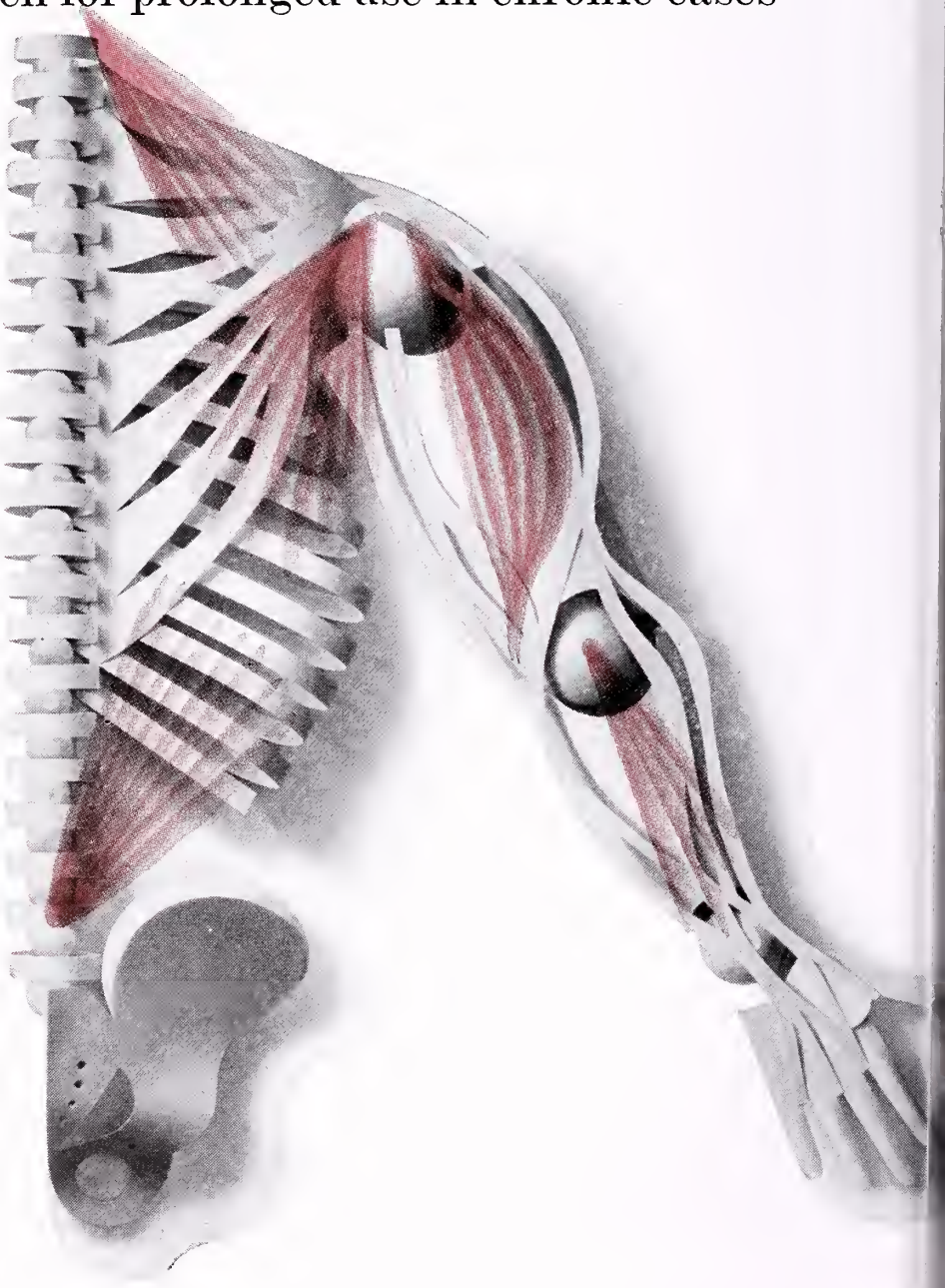
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"In 86 per cent of the patients there were excellent or good results. . . . Relief of pain was noted by the patients' statements, by the diminished need for analgesic drugs, and by improved sleep." (154 patients.) Wein, A.B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on the Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, SOMA was reported to be "clinically effective to a highly significant degree." (92 patients.) Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. *Ibid.* p. 97.

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Literature and samples on request. WALLACE LABORATORIES, New Brunswick, New Jersey

HAWAII MEDICAL ASSOCIATION

(Continued from page 336)

does it very well and effectively. In this respect its activities affect the entire state which could justify the Hawaii Medical Association assisting it financially.

ACTION:

It was moved and passed that we support the Oahu Health Council in direct proportion to the relationship of members from the other islands to members from Honolulu and that we become a supporting member and pay $101.00 dues.

WORKMEN'S COMPENSATION

Dr. Nishigaya reviewed the progress Honolulu County's Fee Adjustment Committee had made with the Bureau of Workman's Compensation in trying to agree upon a fee schedule. They have now tentatively agreed to accept the new California Workman's Compensation Fee Schedule which calls for $6.00 for the first visit. The fee schedule for surgical procedures is less than the Relative Value Fee Schedule but pre and postoperative care are billed for by the visit. There is one stipulation: that the medical societies police the fee schedule to keep it from getting out of hand on such matters as repeat visits. A committee will have to be formed either on a county or state level. Dr. Nishigaya asked that this information be taken back to each county. Dr. Cushnie said that the fee schedule had been sent to different specialty societies. The radiologists said they would accept it but the sooner we get the HMSA fee schedule up to our Relative Value Schedule, the better.

INSURANCE FOR FEDERAL EMPLOYEES

Dr. Nishigaya said that as far as we know the government employees will have a choice of Blue Shield-Blue Cross, commercial insurance companies, or any type panel that is in existence when the program goes into effect. The government pays part of the premium. Mr. George Cooley of the American Medical Association, who met with two of our committees last Sunday, said he had little information but that there would be a government representative present in Dallas on November 30 to explain the details to the medical association representatives who would be present. Dr. Arnold agreed to attend the meeting. The HMSA can go into this if they join the national program but probably few government workers who are now getting home and office visits would be interested. The HMSA has applied for an exception and the only thing we can do now is to wait to see if this is granted.

CYTOLOGY LABORATORY

This item was put on the agenda at the request of Dr Spencer. Dr. Arnold explained that service to patients is something that the American Cancer Society strongly disapproves and so when the local society went national they had to set up a separate agency. It was noted that none of the pathologists in this area objects to such a laboratory and most of them help in the laboratory itself.

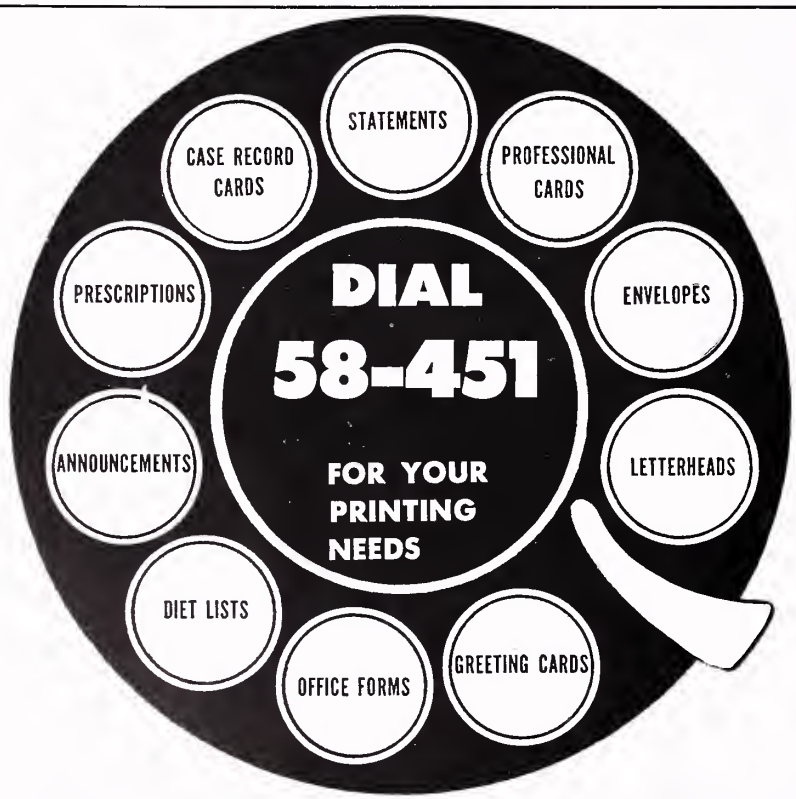
ACTION:

It was voted that we support the continued work of the cytology laboratory that is now being established.

DIRECTOR OF THE DEPARTMENT OF HEALTH

Dr. Nishigaya said that there are still persistent rumors going around that Dr. Lee might be replaced and he wondered if a letter from the Hawaii Medical

(Continued on page 344)



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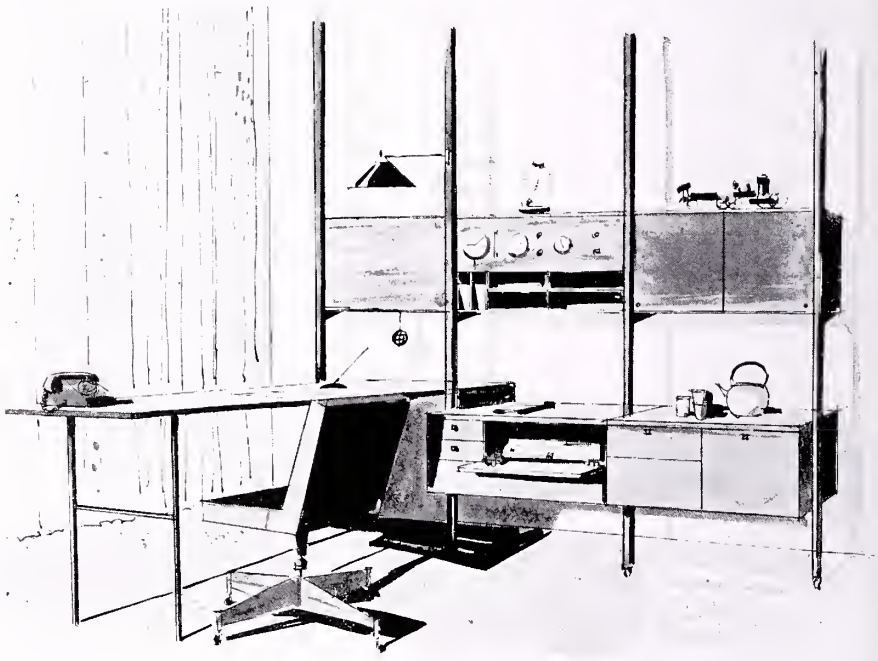
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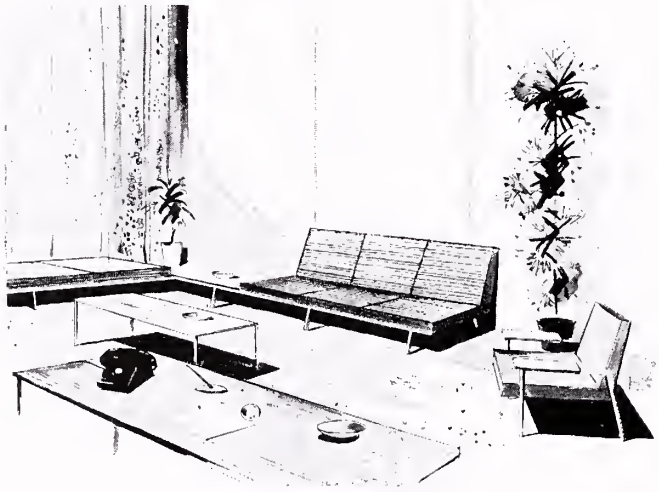
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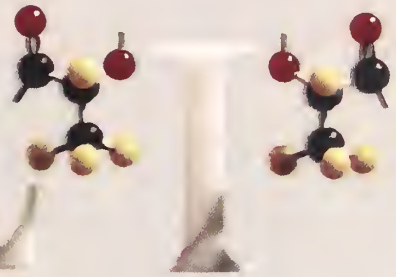


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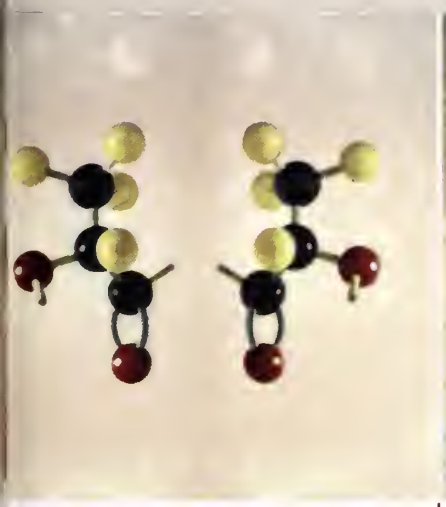
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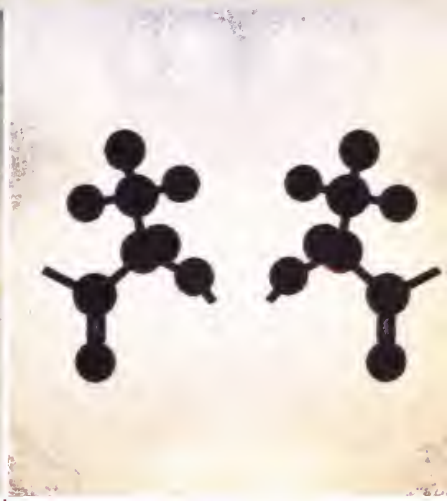


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ORIGIN OF A NEW SYNTHETIC PENICILLIN

In March, 1957, Dr. John C. Sheehan of the Massachusetts Institute of Technology announced the total synthesis of penicillin from common raw materials, thus solving a problem which had baffled research workers for more than 15 years. Although total synthesis was not commercially practicable, this work, sponsored by Bristol Laboratories, made possible the subsequent synthesis of new penicillins not occurring in nature. Later scientists at Beecham Laboratories in England discovered that a key intermediate (6-aminopenicillanic acid) could be produced by a fermentation process. With these achievements, large scale production of synthetic penicillins became feasible.

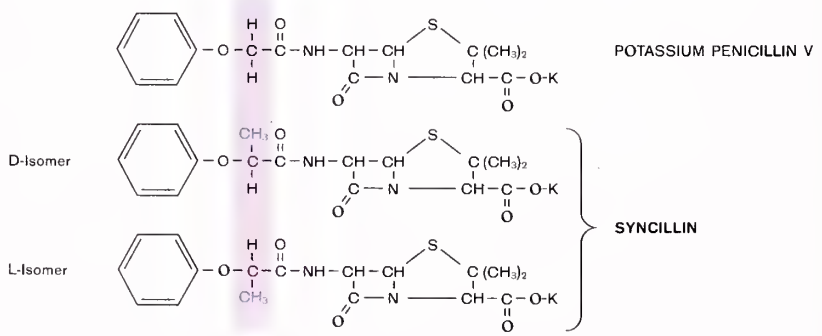
Organic chemists at Bristol then embarked upon an intensive program to develop better penicillins. Over five hundred were synthesized and underwent preliminary screening. Forty-six showed sufficient promise to warrant further investigation. Extensive microbiological, pharmacological, and clinical screening indicated that one compound, SYNCILLIN, had advantages of major importance over other penicillins.

SYNCILLIN is the N-acylation product of 6-aminopenicillanic acid and α-phenoxypropionic acid (the phenylether of lactic acid). It is freely soluble in water and remarkably resistant to decomposition by acid. The acid stability of SYNCILLIN is equivalent to that of penicillin V at pH 2 and pH 3 at 37° C.[1]

SIGNIFICANCE OF MOLECULAR ASYMMETRY AND ISOMERIC COMPLEMENTARITY

SYNCILLIN has a molecular configuration similar to penicillin V, but contains an additional CH_3 group so positioned as to render the adjacent carbon atom asymmetric. (In the formulae below, the added CH_3 group is shown in blue and the asymmetric carbon atom in red.) As a result, SYNCILLIN occurs as a mixture of two isomers.

Each isomer has been synthesized in essentially pure form and found to possess distinctive chemical and biological properties. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. As produced, SYNCILLIN is a mixture of the L-isomer and the D-isomer. As will be shown later, the antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than either isomer alone against many organisms. This phenomenon is referred to here as *isomeric complementarity*.





SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

ISOMERIC COMPLEMENTARITY DEMONSTRATED IN VITRO

The *in vitro* minimum inhibitory concentration (MIC) of SYNCILLIN and of each of its two component isomers was determined for a variety of common pathogens and laboratory test organisms. As may be seen from Table 1, all three are highly effective against penicillin-susceptible staphylococci and against pneumococci, streptococci, gonococci, and corynebacteria; all are ineffective against Salmonella, *E. coli,* and other gram-negative coliform bacilli.

SYNCILLIN was more active against many of the test strains including some streptococci and staphylococci than either of its components. This demonstrates *in vitro* the phenomenon of isomeric complementarity.

TABLE 1

Minimum Concentrations of SYNCILLIN and Components Required to Inhibit a Wide Range of Bacteria

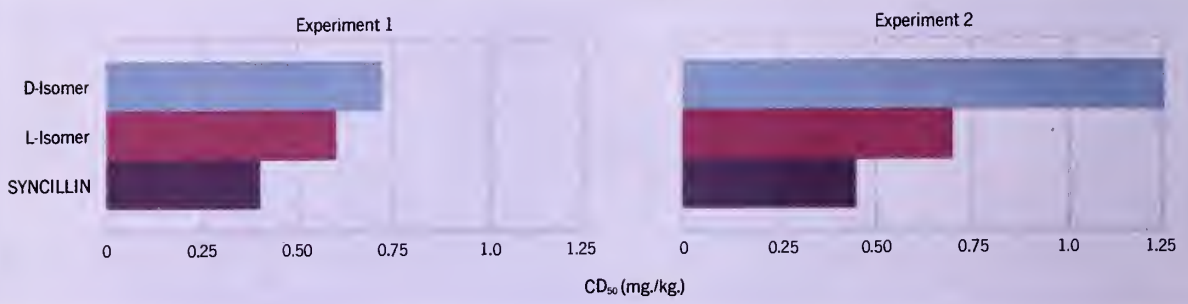
	Minimum Inhibitory Concentration (MIC) in Micrograms per Milliliter		
	L-Isomer	D-Isomer	SYNCILLIN
Bacillus anthracis	0.06	0.25	0.03
Bacillus cereus	12.5	100	25
Bacillus circulans ATCC 9961	6.25	6.25	6.25
Corynebacterium xerosis	0.06	0.125	0.03
*Diplococcus pneumoniae	0.06	0.06	0.06
Escherichia coli ATCC 8739	>100	>100	>100
Gaffkya tetragena	0.015	0.03	0.015
Micrococcus flavus	0.015	0.125	0.015
Salmonella paratyphi A	25	50	25
Salmonella typhosa	>100	>100	>100
Sarcina lutea ATCC 10054	0.007	0.12	0.007
Shigella sonnei	100	100	100
Staphylococcus aureus 209P	0.06	0.125	0.03
Staphylococcus aureus var. Smith	0.03	0.125	0.03
Streptococcus agalactiae ATCC 1077	0.03	0.06	0.03
Streptococcus dysgalactiae ATCC 9926	0.03	0.06	0.03
Streptococcus faecalis PCI 1305	6.25	25	6.25
*Streptococcus pyogenes 203	0.06	0.06	0.06
*Streptococcus pyogenes Digonnet	0.03	0.15	0.06
Streptococcus pyogenes 2320	0.06	0.06	0.03
Streptococcus pyogenes 23586	0.06	0.06	0.06
Vibrio comma	50	25	25

Serial dilution technique in heart infusion broth *10% serum added

ISOMERIC COMPLEMENTARITY CONFIRMED IN VIVO

To determine the median curative dose (CD_{50}) mice were infected with 100 times the lethal dose of *Staphylococcus aureus*. Each penicillin being tested was administered intramuscularly at the same time, and the dose required to cure half the animals determined. The greater effect of the mixture of the two isomers (SYNCILLIN) is shown in two independent experiments. (See Figure 1.) Note that isomeric complementarity is thus confirmed *in vivo*.

FIGURE 1 — Median Curative Dose (CD_{50}) for *Staphylococcus aureus* (var. Smith) Infections

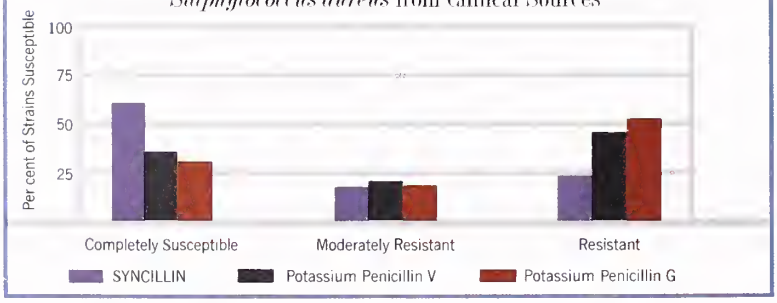


MANY STRAINS OF STAPHYLOCOCCI MORE SENSITIVE TO SYNCILLIN

SYNCILLIN has been tested against a large number of strains of *Staphylococcus aureus* isolated from clinical sources. Many organisms resistant to potassium penicillin G and potassium penicillin V proved sensitive to SYNCILLIN.

Wright[2] performed sensitivity studies on 54 strains, the majority of which were resistant or moderately resistant to penicillin V and penicillin G. Thirty-two (60%) of the strains were sensitive to SYNCILLIN, approximately twice as many as with the other penicillins. (See Figure 2.) In two-thirds of the isolates, SYNCILLIN produced inhibition at concentrations lower than those required for either of the other antibiotics. One strain was more sensitive to penicillin G.

FIGURE 2 — *In Vitro* Sensitivity of 54 Strains of Coagulase-Positive *Staphylococcus aureus* from Clinical Sources

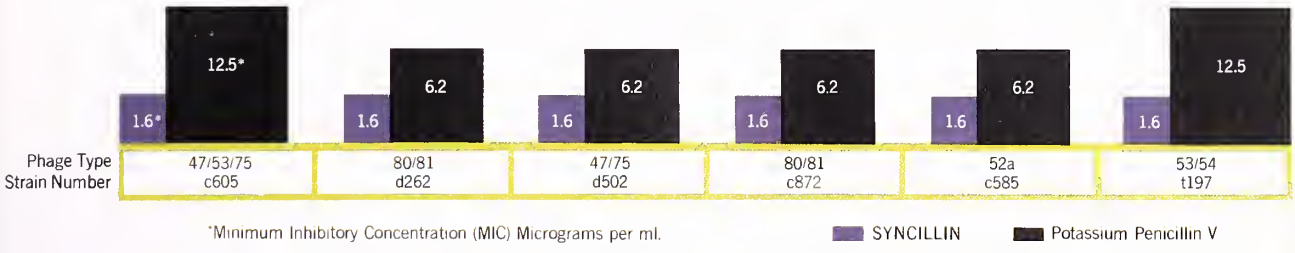


Adapted from Wright[2]

Of equal interest are the findings of White.[3] Six penicillin-resistant strains of staphylococci were isolated from hospital infections. None was sensitive to potassium penicillin V. All were sensitive to SYNCILLIN. (See Figure 3.)

FIGURE 3

Minimum Concentrations of SYNCILLIN Required to Inhibit Hospital Strains of *Staphylococcus aureus* Resistant to Potassium Penicillin V

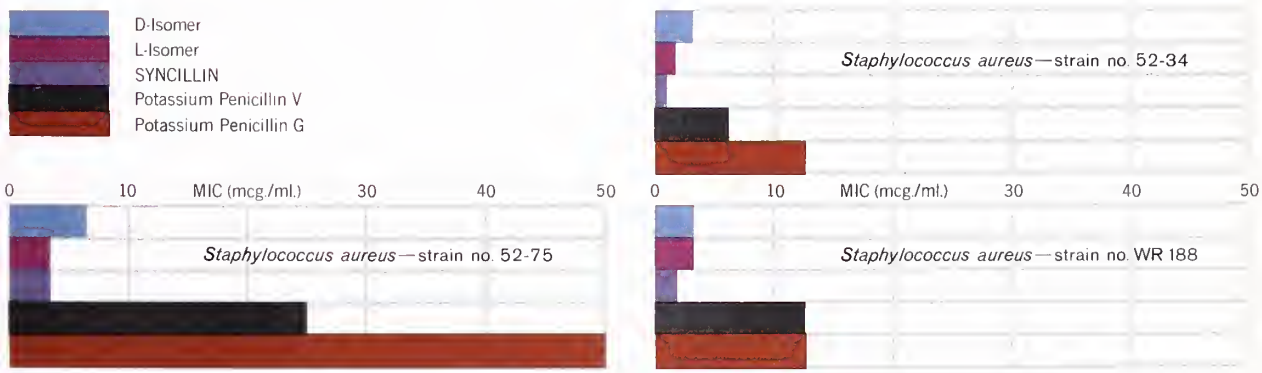


The efficacy of SYNCILLIN against the type 80/81 Staphylococcus (dangerous and widespread in hospitals) is worthy of special attention.

The complementary action of the component isomers is also seen with strains of staphylococci resistant to penicillins. Note that SYNCILLIN is more effective than either isomer against strains 52-34 and WR 188. (See Figure 4.) Against all three strains, SYNCILLIN is effective at concentrations below serum levels, while penicillins V and G are ineffective.

FIGURE 4

Minimum Inhibitory Concentrations (MIC) for Coagulase-Positive Penicillin-Resistant Strains of *Staphylococcus aureus*



Isomeric complementarity has thus been demonstrated for:

— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

— *penicillin-susceptible staphylococci* in vivo *(Figure 1)*

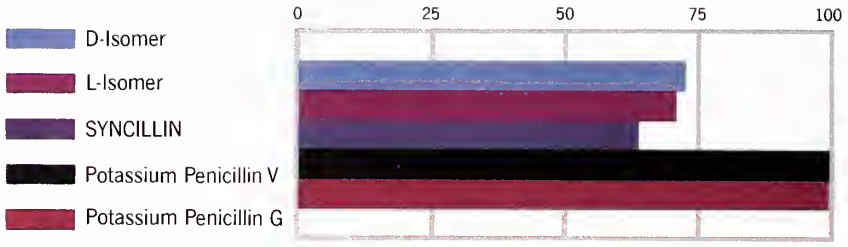
— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

ISOMERIC COMPLEMENTARITY SHOWN BY REDUCED RATE OF INACTIVATION BY PENICILLINASE

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms.[4] As shown in Figure 5, SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers – a further demonstration of isomeric complementarity. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G.

Resistance to SYNCILLIN develops in a slow, step-wise manner characteristic of other penicillins, in contrast to the usually rapid development of resistance to streptomycin.

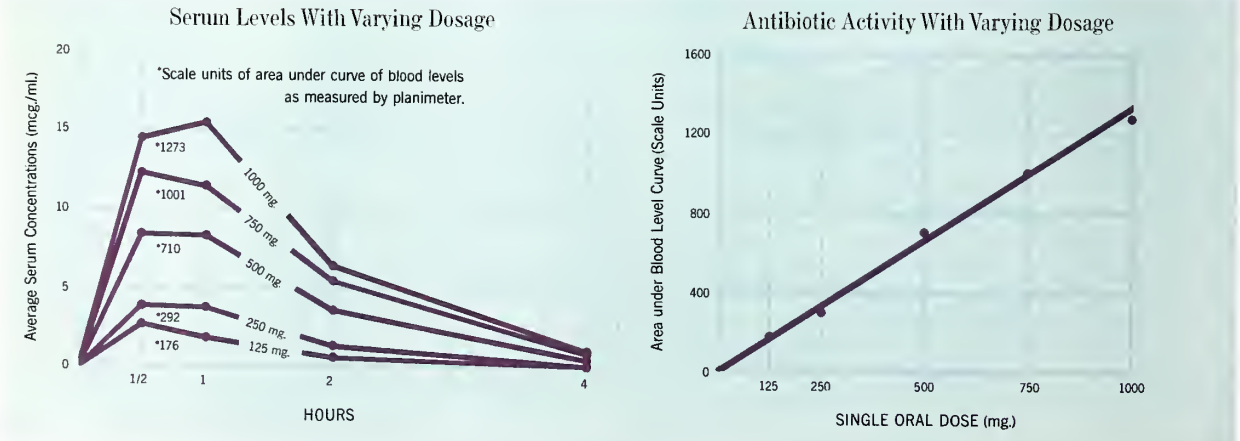
FIGURE 5—Effect of Staphylococcal Penicillinase on Different Penicillins



ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSAGE

Cronk[5] studied blood levels after administering varying amounts of SYNCILLIN. (Figure 6.) Total antibiotic activity (obtained by measuring areas under curves with a planimeter) increases rapidly as the dose is doubled. These data show that increased dosage markedly increases serum concentration and thus may enhance the drug's effectiveness.

FIGURE 6



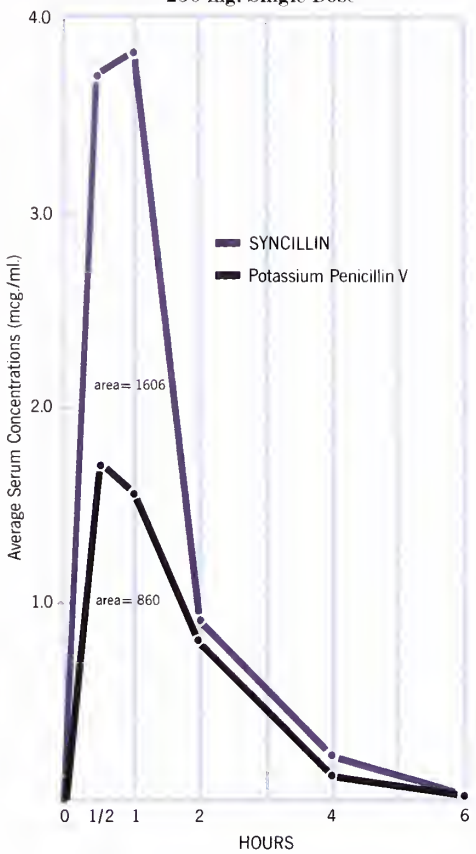
BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V AFTER ORAL ADMINISTRATION

Wright[6] performed comparative crossover blood level studies on volunteer subjects receiving equivalent amounts of potassium penicillin V and SYNCILLIN. The peak concentrations attained during the first hour after administration were twice as high with SYNCILLIN.

The total antibiotic activity as measured by the area under the curves (see Figure 7) indicates an almost 2 to 1 superiority of SYNCILLIN (1606) over potassium penicillin V (860).

The higher blood levels may be of value with organisms of only moderate penicillin-sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition these higher levels may be necessary where there is infection in areas with a poor blood supply.[7] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue.

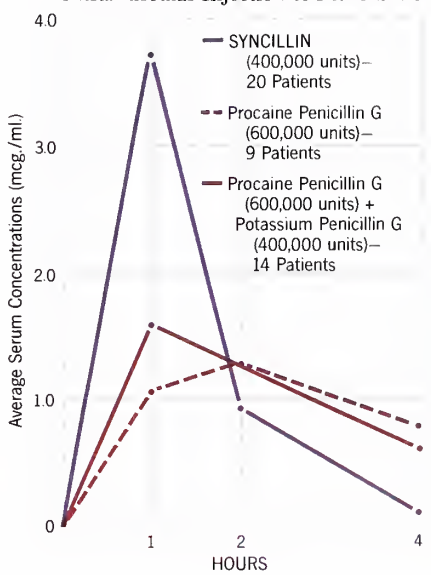
FIGURE 7
20 Subject Crossover
250 mg. Single Dose



BLOOD LEVELS MUCH HIGHER THAN WITH INTRAMUSCULAR PENICILLIN G

In addition, blood levels attained with oral SYNCILLIN[6] are much higher than those with intramuscular penicillin G.[8a, b] (See Figure 8.) Note that the level at one hour for SYNCILLIN (3.8 mcg./ml.) is more than twice as high as with procaine penicillin G, even when reinforced with potassium penicillin G (1.6 mcg./ml.). Since penicillins are *bactericidal,* these intermittent high serum levels can be clinically significant. Thus, SYNCILLIN offers the promise of superior efficacy via the safer oral route.

FIGURE 8—Serum Levels after Oral Administration of SYNCILLIN (250 mg.) and after Intramuscular Injection of Penicillin G



REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

SYNCILLIN has been administered in multiple doses to 437 patients and volunteers. One patient developed itching during therapy, possibly an allergic side effect. Another had a purpuric rash, but no relationship to SYNCILLIN was established. No reactions were observed in 9 patients with a known history of sensitivity to penicillin.

While the above data suggests the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *The usual precautions for oral penicillin therapy should be observed.* Patients with histories of asthma, hay fever, urticaria, or previous penicillin-sensitivity should especially be watched carefully. Since SYNCILLIN is administered orally, it may be expected to be safer than parenteral penicillin.

As Flippin[9] recently stated, ". . . it is well established that serious allergy to the drug [penicillin] is most likely to occur following parenteral administration, especially after repeated intramuscular injections; the oral route is least likely to initiate severe hypersensitivity reactions. This can be explained partly by the fact that when reactions develop following oral medication, they are usually slow enough to treat symptomatically; thus the progression of the reaction can usually be interrupted. . . . In view of the relatively high incidence of severe allergy to injectable penicillin, it would seem advisable to employ oral penicillin routinely, except in the control of infections involving the blood stream, endocardium, meninges, etc., in which cases the parenteral route remains the preferred treatment."

SYNCILLIN, like other penicillins, is essentially free of other toxicity. No hematopoietic, hepatic, or renal toxicity was observed in 210 volunteers receiving 1 gm. daily for 2 to 3 weeks.[10]

CLINICAL EFFICACY DEMONSTRATED IN PENICILLIN-SENSITIVE INFECTIONS

Clinical trials conducted by Blau and Kanof,[11] White,[12] Prigot,[13] Robinson,[14] Dube,[15] Ferguson,[16] Rutenburg,[17] Richardson,[18] Bunn,[19] Cronk,[5] Kligman,[10] and Yow [20] demonstrated the efficacy of SYNCILLIN in a variety of streptococcal, staphylococcal, pneumococcal, and gonococcal infections. Conditions treated included respiratory, skin, soft tissue, wound, and chronic urinary tract infections; acute gonorrhea; cellulitis; septicemia; otitis media; gingivitis; and Vincent's angina. In a few patients SYNCILLIN was used for rheumatic fever or gonorrheal prophylaxis.

One hundred seventy-two of one hundred ninety-six patients responded favorably to SYNCILLIN. The failures included 1 patient with pustular dermatoses, 10 elderly patients with chronic urinary tract infections, 1 patient with gonorrhea, 1 patient with a gram-negative infection, and 10 patients with staphylococcal infections. Lack of response of staphylococcal infections was attributed to the presence of resistant organisms or local suppurative foci requiring drainage.



Relatively few side effects were encountered. One patient experienced moderate itching of the skin which was controlled by an antihistamine. Another reported pruritus ani which did not interfere with therapy. Diarrhea occurred in 4 instances. There was one purpuric rash, but no relationship to SYNCILLIN could be established.

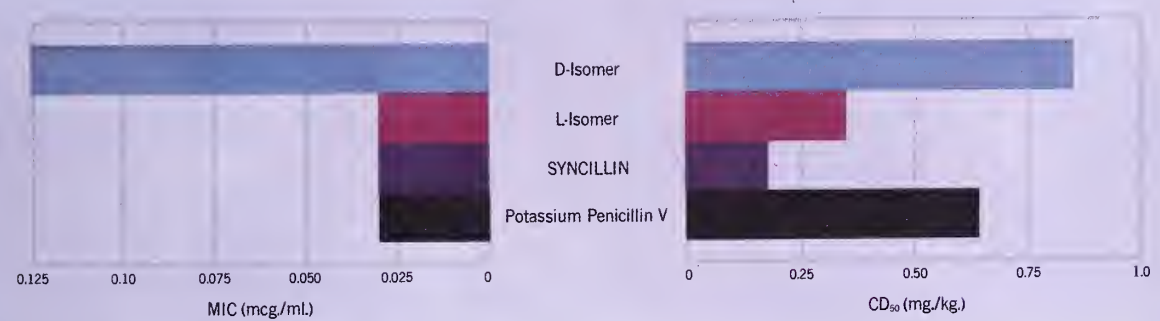
Clinical response usually begins within 24 hours in infections susceptible to SYNCILLIN. Recovery occurs in 4 to 7 days depending upon the severity of the infection. Gonorrheal infections respond very promptly to SYNCILLIN; 500 mg. b.i.d. for two days usually produce bacteriologic cures.

IMPROVED ANTIBIOTIC EFFECT FROM COMPLEMENTARY ACTION OF ISOMERS

SYNCILLIN is a mixture of isomers. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. Furthermore, the D- and L-isomers have other distinguishing chemical, pharmacological, and microbiological properties. Their *in vivo* and *in vitro* activities differ for many important pathogens. *Against many of the organisms tested, the combination of isomers* (SYNCILLIN) *is much more active than the stronger isomer alone.* This phenomenon of isomeric complementarity is not always demonstrable, for in a few instances SYNCILLIN is slightly less active.

Isomeric complementarity has previously been demonstrated *in vitro* (Figure 4) and *in vivo* (Figure 1). Figure 9 reveals a third form of superiority related to isomeric complementarity. Equal concentrations of SYNCILLIN and penicillin V were required to inhibit this growth of staphylococci *in vitro.* But, *in vivo,* a much smaller amount of SYNCILLIN *(one-third that of penicillin V)* was effective in an experimental infection with the same strain. These observations on complementary action indicated the advantage of producing the mixture of isomers as the medication to be made available for clinical therapy.

FIGURE 9—Comparison of CD_{50} and MIC Values Against *Staphylococcus aureus* (var. Smith)



Isomeric complementarity has thus been demonstrated for:

—— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

—— *penicillin-susceptible staphylococci* in vivo *(Figures 1 and 9)*

—— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

—— *staphylococcal penicillinase antibiotic inactivation (Figure 5)*

Indications:

SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins.

SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage:

125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals.

Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions:

While present data suggest the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *Therefore the usual precautions with oral penicillin therapy must be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, the interval between dosages should be lengthened.

If superinfection occurs during therapy, appropriate measures should be taken.

Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply:

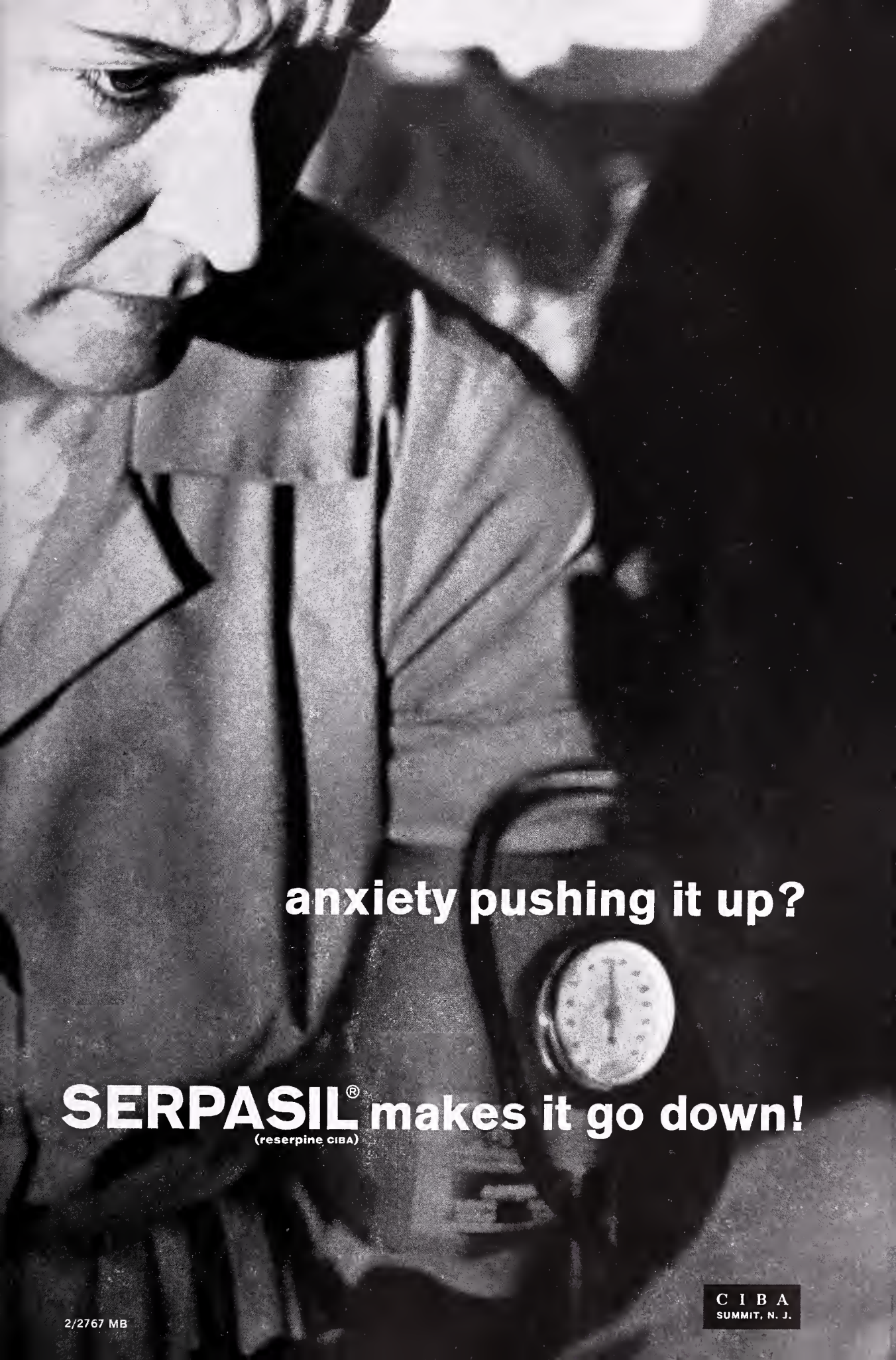
125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Lein, J.: Microbiology report to Bristol Laboratories Inc. 2. Wright, W. W.: Microbiology report to Bristol Laboratories Inc. 3. White, A. C.: Microbiology report to Bristol Laboratories Inc. 4. Dubos, R. J.: Bacterial and Mycotic Infections of Man, 3rd edition, Philadelphia, J. B. Lippincott Co., p. 690. 5. Cronk, G. A.: Clinical report to Bristol Laboratories Inc. 6. Wright, W. W.: Clinical report to Bristol Laboratories Inc. 7. Kass, E. H.: Am. J. Med. *18*:764 (May) 1955. 8a. White, A. C.; Couch, R. A.; Foster, F.; Calloway, J.; Hunter, W., and Knight, V.: in Welch, H. and Marti-Ibañez, F.: Antibiotics Annual — 1955-1956, Medical Encyclopedia, Inc., New York, 1956, p. 490. b. Data on file — at Bristol Laboratories. 9. Flippin, H. F.: Pennsylvania M. J. *62*:864 (June) 1959. 10. Kligman, A.: Clinical report to Bristol Laboratories Inc. 11. Blau, S., and Kanof, N.: Clinical report to Bristol Laboratories Inc. 12. White, A. C.: Clinical report to Bristol Laboratories Inc. 13. Prigot, A.: Clinical report to Bristol Laboratories Inc. 14. Robinson, C.: Clinical report to Bristol Laboratories Inc. 15. Dube, A. H.: Clinical report to Bristol Laboratories Inc. 16. Ferguson, B.: Clinical report to Bristol Laboratories Inc. 17. Rutenburg, A. M.: Clinical report to Bristol Laboratories Inc. 18. Richardson, J. H.: Clinical report to Bristol Laboratories Inc. 19. Bunn, P. A.: Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.: Clinical report to Bristol Laboratories Inc.

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HAWAII MEDICAL ASSOCIATION

(Continued from page 340)

Association to Governor Quinn was in order. It was suggested that a letter to the Lieutenant Governor might also be in order.

ACTION:

It was voted and passed that the President should write to the Governor urging that Dr. Richard K. C. Lee be retained.

MISCELLANEOUS BUSINESS

Dr. Cushnie reported on his trip to St. Louis for a legislative meeting of the American Medical Association at which all states except Alaska were represented. The meeting was called for the purpose of defeating the Forand Bill. He said that it was an intensive conference with meetings starting early in the morning and continuing until six or seven at night. It was a good meeting and there were many fine speakers. His impression was that there were a lot of people that didn't know which way to go or how to defeat it. Dr. Cushnie read from a report that was sent him. The meeting was conducted on the basis of attempting to indoctrinate the delegates with information for them to disseminate when they returned home. The proponents of the bill were also heard during the conference. The matter of lack of insurance to cover the over-sixty-five group was outlined. Dr. Nishigaya told of the work the Committee on Chronic Illness and Aging is doing on this subject and Dr. Arnold proposed that an editorial be published in the next issue of the JOURNAL.

The meeting was adjourned at 10:55 p.m.

RAYMOND C. YAP, M.D.
Secretary

BOOK REVIEWS

(Continued from page 312)

information. The greater portion of the book is devoted to a minimum of wordiness and a maximum of illustrations, all of which are exceptionally well done. To single out any particular operative procedure outlined in the volume would be to detract from the others. However, I believe the section on cardiovascular surgery, and in particular that of vascular surgery, is especiallly interesting and valuable since little of it has been presented in such clear-cut manner in other surgical volumes. There can be no question this volume is a valuable addition to any medical library and of great value and importance to the surgeon, however well trained, who feels the necessity of occasional reference as to technics and anatomy.

JOHN F. CHALMERS, M.D.

Case Histories in Hypnotherapy

By Arnold Furst and Lester T. Kashiwa, M.D., 163 pp., $10.00, The Genii Publishing Co., 1959.

This book is written by a lay person using some of the clinical material of a physician. It briefly covers methods of induction of hypnosis and relates various types of cases in which hypnosis was used to alleviate symptoms. In all of the cases cited the sole usage of the hypnosis was symptom removal, with the exception of one case of enuresis in which a physician was asked to investigate the basis for the patient's bed-wetting. The general opinion amongst those who use hypnosis medically is that removal of symptoms, alone, without deeper

(Continued on page 346)

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BOOK REVIEWS

(Continued from page 344)

investigation of the basis of the symptoms is not to be encouraged. The case histories presented give the impression that hypnotherapy is simple and completely finished in one or two visits. This is misleading and can cause much disappointment to the uninitiated. The cases, however, do illustrate the wide applicability of hypnosis in medicine.

DUKE CHO CHOY, M.D.

Practical Dermatology, 2d Ed.

By George M. Lewis, M.D., F.A.C.P., 363 pp., $8.00, W. B. Saunders Company, 1959.

This is a small volume published primarily for medical students. It has many good photographic illustrations. The descriptions of diseases are often too brief to be helpful. Treatments recommended are up to date in most instances. It would be worthwhile to glance through this book and look at the photographs.

EDWARD EMURA, M.D.

Pathology, 2d Ed.

By Peter A. Herbut, M.D., 1516 pp., $18.50. Lea & Febiger, 1959.

This is a well organized, concise, and encyclopedic presentation designed for the student in pathology. The large size of the text is the result of widely spaced, relatively large print and numerous excellent photographs. The latter thus more than adequately justifies the sacrifice of volume of words.

PAUL Y. TAMURA, M.D.

British Medical Bulletin, Vol. 15, No. 2

K. L. G. Goldsmith, M.D., Scientific Editor, pp. 89-174, May, 1959.

This excellent symposium should be of interest not only to the hematologist, but to the medical profession in general and to allied scientific disciplines. The contributors represent various research fields, such as hematology, genetics, immunology, biochemistry, and others.

Fourteen presentations make up this symposium, each one is relatively short and concise. Subjects discussed range from "Inheritance of Blood Groups" to "Haemagglutinins in Seeds." Authors report not only on results of their personal research, but summarize the facts of today. Many references add to the value of this symposium.

It is indeed a pleasure to recommend this number of the *British Medical Bulletin.*

LÉON E. MERMOD, M.D.

Fracture Surgery

By Henry Milch, M.D., and Robert Austin Milch, M.D., 470 pp., $17.50, Paul B. Hoeber, Inc., 1959.

This book is a first edition on the subject of common fractures. It is well-written with excellent illustrations and hundreds of x-rays. The book is 470 pages long and touches all phases of fracture treatment including emergency care and regional anesthesia.

The book is well planned and has a good index. I recommend it for physicians in need of a ready and well illustrated reference.

B. ALLEN RICHARDSON, M.D.

★ The Surgeon and the Child

By Willis J. Potts, M.D., 255 pp., $7.50, W. B. Saunders Co., 1959.

"This is not a standard textbook of pediatric surgery . . . An attempt has been made to reflect the attitude of the surgical staff at the Children's Memorial Hospital of Chicago toward some of the surgical problems common to infants and children." This is the essence of a thoroughly enjoyable book by one of pediatric surgery's pioneers. Sprinkled with anecdotes garnered through 30 years experience with children; dogmatic at times with controversial subjects; a little overly sentimental in its first chapters; yet readable as a good novel—this book is recommended reading for *any* physician.

WM. F. MOORE, M.D.

The Manual of Chest Clinic Practice

By A. J. Benatt, M.D., 100 pp., $3.00, The Williams & Wilkins Co., 1959.

This small, compact manual, though specifically entitled for tropical and sub-tropical countries, can be used by any health department organizing or setting up clinics, especially in rural communities. It is divided into two main sections plus an appendix. The first section deals with the organization of the chest clinic and the treatment of tuberculosis. The second section discusses laboratory procedures with special emphasis on tuberculin testing and BCG vaccination. The appendix is concerned with the equipment and setting up of a small laboratory and the cleaning and sterilizing equipment for tuberculin testing and BCG vaccination.

The manual is well written. Each chapter is concise, comprehensive, and well organized. No time is wasted on theoretical discussion or controversial subjects. Everything is outlined in simple, readable English, and it is amazing how much detailed instruction the author is

(Continued on page 348)



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(Continued from page 346)

able to give in such a short work. He not only covers every medical aspect of the chest clinic, including the precise duties of the various personnel, but he also gives much valuable advice on dealing with patients, particularly the recalcitrant ones. Certainly this would be a most helpful and instructive book for any public health worker who would have the responsibilities of setting up a chest clinic.

MAURICE L. BRODSKY, M.D.

Also Received
With Apologies for the Delay

The Medical Clinics of North America, Vol. 43, No. 5

Chester S. Keefer, M.D., Consulting Editor, pp. 1355-1567, W. B. Saunders Company, September, 1959.

A symposium on viral and rickettsial diseases plus an additional article on the management of transfusion reactions.

★Diabetic Manual, 10th Ed.

By Elliott P. Joslin, M.D., Sc.D., 304 pp., $3.75, Lea & Febiger, 1959.

The author's name is enough recommendation for this book on diabetes. This tenth edition is full of the most recent information, including a discussion of oral hypoglycemic agents. The ninth edition came out six years ago. You need the new one!

The Surgical Clinics of North America, Vol. 39, No. 4

Mayo Clinic Number, pp. 875-1148, W. B. Saunders Co., August, 1959.

A symposium on urology and gynecology.

A Manual of Anaesthetic Techniques, 2d Ed.

By William J. Pryor, M.B., Ch.B.(N.Z.), F.F.A.R.C.S. (Eng.), D.A. (Eng.), F.F.A.R.A.C.S., and J. H. T. Challis, M.R.C.S. (Eng.), L.R.C.P. (Lond.), F.F.A.R.C.S. (Eng.), D.A. (Eng.), 228 pp., $7.00, The Williams & Wilkins Co., 1959.

Basic British an*aes*thesiology. For anesthesiologists—amateur rather than full-time.

Synopsis of Treatment of Anorectal Diseases

By Stuart T. Ross, M.D., F.A.C.S., F.I.C.S., 240 pp., $6.50, The C. V. Mosby Co., 1959.

The first manual of proctology for thirty years. So says Dr. Harry Bacon in his laudatory foreword to this compact, well illustrated little volume.

History and Trends of Professional Nursing, 4th Ed.

By Deborah MacLurg Jensen, R.N., B.S., M.A., John F. Spalding, LL.B., and Elwyn L. Cady, Jr., LL.B., B.S., Med., 610 pp., $5.25, The C. V. Mosby Co., 1959.

Nurses in higher supervisory and teaching echelons will want to—and should—read this thoughtful long-range treatise on nursing in relation to world society

(Continued on page 350)

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BOOK REVIEWS

(Continued from page 348)

and world history. Hospital administrators would do well to read it too.

★Annals of the New York Academy of Sciences, Vol. 73, Art. 2 (Surgical Convalescence)

By Ed. in Chief Otto V. St. Whitelock, 157 pp., $4.00, The New York Acdaemy of Sciences, 1958.

Ten valuable papers on various aspects of the patient's recovery from major surgery. Introduction by I. S. Ravdin. Well worth the price—and the time—to *any* surgeon.

Progress in Hematology, Vol. II

Edited by Leandro M. Tocantins, M.D., 290 pp., $6.00, Grune & Stratton, 1959.

An authoritative symposium. For hematologists.

An Introduction to Child Psychiatry

By Stella Chess, M.D., 254 pp., $5.25, Grune & Stratton, 1959.

Child psychiatry step by step, with illustrative cases, in remarkably straightforward language.

Synopsis of Ophthalmology

By William H. Havener, B.A., M.D., M.S., 288 pp., $6.75, The C. V. Mosby Co., 1959.

A well printed, concise, pocket-size compendium, written by the Professor of Ophthalmology at Ohio State University.

Fundamentals of Clinical Neurophysiology

By Paul O. Chatfield, M.D., 392 pp., $8.50., Charles C. Thomas, 1957.

Lucid, readable, and profusely illustrated with photographs and diagrams, this beautifully printed volume is aimed at neurologists, neurosurgeons and physiologists primarily.

★Peripheral Circulation in Health and Disease

By Walter Redisch, M.D., F.A.C.P., Francisco F. Tangeo, M.D., B.S., 154 pp., $7.75, Grune & Stratton, Inc., 1957.

An orderly, concise, authoritative presentation by an Associate Professor of Internal Medicine at N.Y.U. College of Medicine. Section V is a beautifully illustrated discussion of the anatomical basis of the peripheral circulation with arteriograms and diagrams. There are 240 references and a good index.

Men, Molds, and History

By Felix Marti-Ibanez, M.D., 114 pp., $3.00, MD Publications, Inc., 1958.

Antibiotics in historical perspective—by one of America's leading medical scholars, writers and editors. Provocative and philosophical.

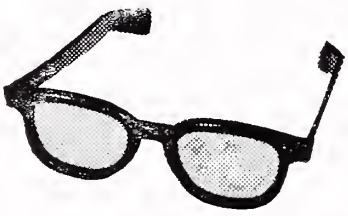
★Medical Radiographic Technic, 2d Ed.

By Glen W. Files, 386 pp., $11.00, Charles C. Thomas 1959.

"Written by technicians for technicians." The first edition came out in 1943. Better replace it!

(Continued on page 352)

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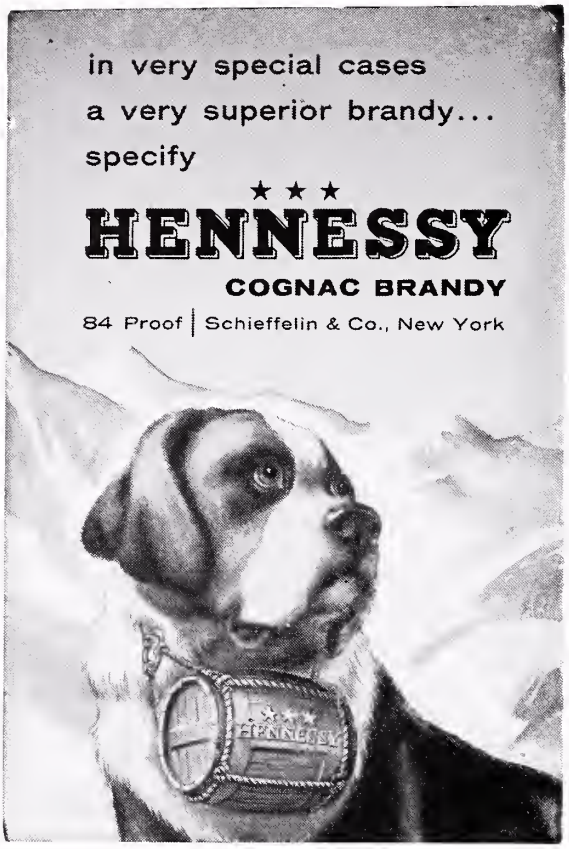
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Miller, R. F.: Clin. Rev. 1:10 (July) 1958

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HAWAII—The First Trust Co. of Hilo Tel. 51-124

BOOK REVIEWS

(Continued from page 350)

Color Atlas and Management of Vascular Disease

By William T. Foley, M.D., F.A.C.P., and Irving S. Wright, M.D., F.A.C.P., 170 pp., $18.00, Appleton-Century-Crofts, Inc., 1959.

Beautiful pictures. The classification of purpuras is shockingly antiquated. Major peripheral vascular disease is well presented, however.

Obstetrics and Gynaecology, 6th Ed.

Edited by Duglad Baird, B.Sc., M.D., D.P.H., F.R.C.O.G., 936 pp., $15.00, The William & Wilkins Co., 1957.

Six editions in 34 years suggest a good book. It is aimed more at students, however, than at practitioners.

The Kinetics of Cellular Proliferation

Edited by Frederick Stohlman, Jr., M.D., 456 pp., $5.75, Grune & Stratton, 1959.

Important reference work, beautifully printed, but very deep.

What Next, Doctor Peck?

By Joseph H. Peck, M.D., 209 pp., $3.50, Prentice Hall, Inc., 1959.

An unsophisticated tale of a third of a century of general practice in the West.

★Resuscitation of the Unconscious Victim

By Peter Safar, M.D., and Martin C. McMahon, 79 pp., $1.75, Charles C. Thomas, 1959.

A must for first aid teachers and workers.

Systemic Lupus Erythematosus

Edited by George Baehr, M.D., and Paul Klemperer, M.D., 84 pp., $3.75, Grune & Stratton, 1959.

A collection of instructive articles by internists, pathologists, and pediatricians, from Mt. Sinai Hospital.

The Surgical Clinics of North America, Vol. 39, No. 4

Pp. 875-1148, W. B. Saunders, August, 1959.

A Mayo Clinic symposium on urology and gynecology. Thirteen urological papers and a dozen on gynecologic problems.

Aids to Neurology, 2d Ed.

By E. A. Blake Pritchard, M.A., M.D., F.R.C.P., 479 pp., $4.00, Williams & Wilkins Company, 1959.

A bargain—at less than 1 cent a page—in a student's compendium of neurology.

Dynamic Psychopathology in Childhood

Edited by Lucie Jessner, M.D., and Eleanor Pavenstedt, M.D., 315 pp., $8.75, Grune & Stratton, 1959.

For pediatricians with a strong psychiatric bent—or psychiatrists. Pretty deep.

Progress in Psychotherapy, Vol. IV

Edited by Jules H. Masserman, M.D., J. L. Moreno, M.D., 361 pp. $8.75, Grune & Stratton, 1959.

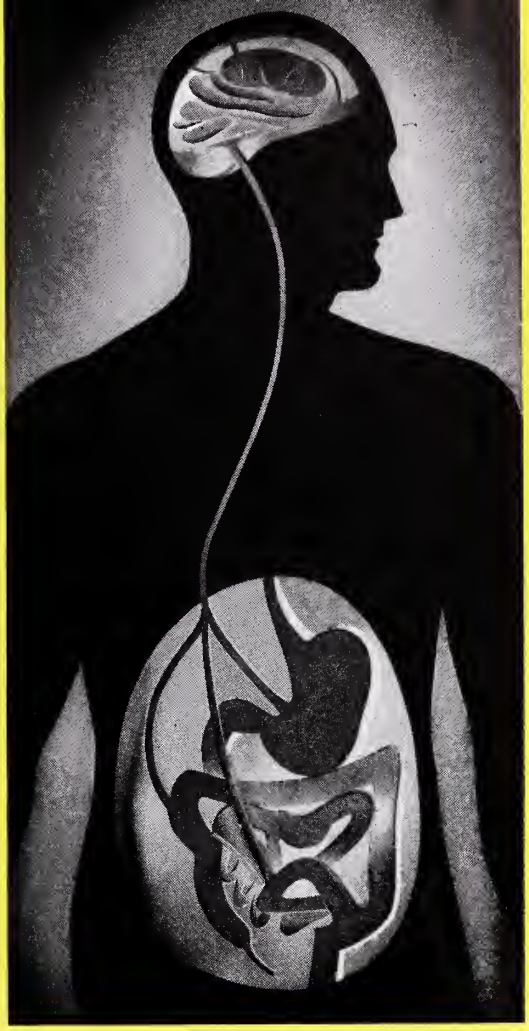
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(Continued from page 318)

Dr. Frank Tabrah of Kohala, who spent the past summer in Africa, was the guest speaker. He presented an absorbing talk illustrated with colored slides. His subject was "Health, Sanitation, and Medicine in the Nigerian Jungle." The eighteen members present all wished Dr. Tabrah could have devoted more time to his most interesting presentation.

During the short business meeting, Dr. Bergin was named Chairman of the Nominating Committee and Drs. Miyamoto and Yuen members of the Committee.

Application for membership from Dr. Robert Pottinger was turned over to the Chairman of the Censorship Committee.

At adjournment time many Hilo members commented that the Hamakua Coast doctors, who played hosts at the meeting, had done their job so well that they wished meetings could be held in Honokaa more frequently.

HAROLD LEWIS, M.D.
Secretary

Honolulu

The Honolulu County Medical Society met in Mabel Smyth auditorium on September 1, 1959. President Thomas Richert presided. Approximately 76 members were present.

A documentary film on space medicine entitled "Vertical Frontier" was shown followed by a short, ten-minute cartoon on space. A panel discussion on the progress, problems, and experiments of space and space travel was held by Col. Wayne Miller, M.D., Lt. Col. David Beyer, M.D., Lt. Col. David L. Henderson, and Lt. Bernie Estefan. Brigadier General Richard L. Bohannon, M.D., of Headquarters Pacific Airforce introduced the speakers. A question and answer period followed.

President Richert introduced new members Drs. Richard S. Omuro, Henry A. Manayan, and Francis Munson. Other new members not present were announced. They are Drs. Herbert M. Nam, Cyrus W. Yee, John R. Brown, and Charles V. Bergquist.

Mr. Kennedy reported that only about 65 applications were received whereas 75% participation is needed before the group life insurance program can be implemented. A question and answer period followed. Several asked whether ordinary life can be planned in a group basis.

President Richert announced that the HCMS will again act as a team in the Community Chest Drive and that the HCMS will approach all members.

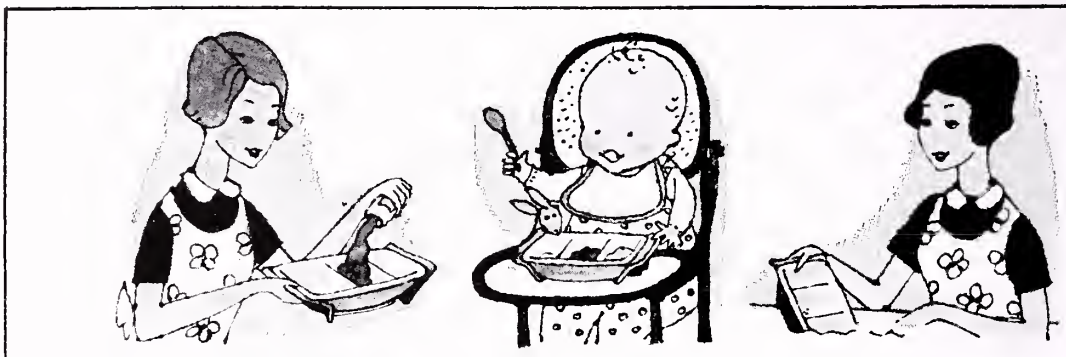
Dr. Leabert Fernandez, Chairman of the Legislative Committee requested that members fill in the questionnaires sent by this Committee on members' acquaintances with legislators.

Dr. Lowrey reported that about 58 of the membership had made generous contributions to the Medical Library and urged the others to do so.

The Committee on Resolutions reported a resolution which was read by its chairman and adopted as follows:

Resolved **that the Honolulu County Medical Society mourns the untimely passing on 3 July, 1959 of its member, George William Bachmann, Jr., Doctor of Medicine, and further, be it resolved that this memorial and resolution be spread upon the minutes of the Society and that copies be sent to his widow.**

(Continued on page 356)

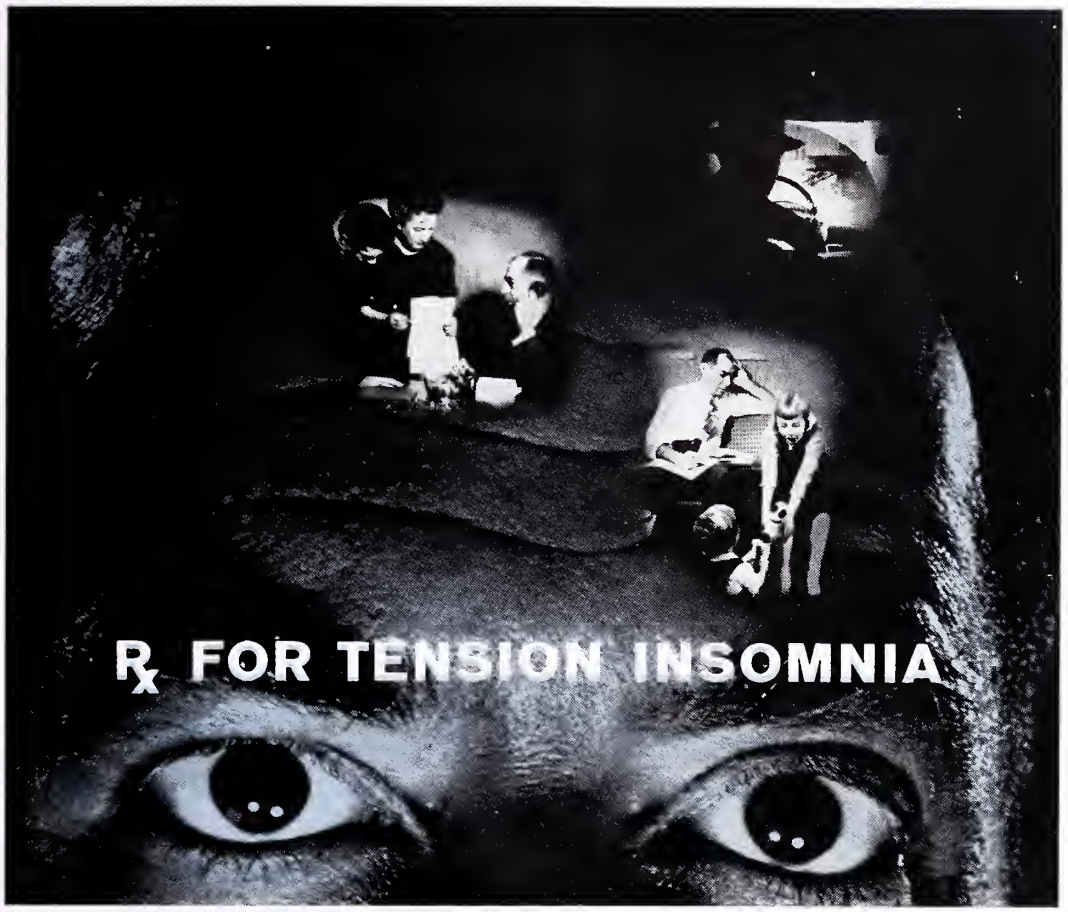


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COUNTY SOCIETY REPORTS

(Continued from page 354)

Motion for adoption was made by Dr. Chung-Hoon and passed unanimously with a rising vote. A few moments of silence in respect to Dr. Bachmann, Jr., was observed.

A motion that the Honolulu County Medical Society Membership go on record in favor of health services under a Health Department not to be combined with other services in the new State government was made by Dr. Grover H. Batten, seconded and passed. The President was requested to send letters to the Governor, President of the Senate, Speaker of the House, and President of the HMA.

There being no further business the meeting was adjourned at 10:13 P.M.

* * *

A joint membership meeting of the Honolulu County Medical Society and the Hawaii Bar Association was held Tuesday, October 6, 1959, at 7:30 P.M. at the Mabel Smyth Auditorium. Dr. Thomas H. Richert presided and approximately 150 doctors and lawyers were present. Dr. Richert opened the meeting with a few words of greeting to the lawyers.

A movie entitled "No Margin For Error," produced in cooperation with the American Medical Association and the American Hospital Association, was shown and was followed by a panel discussion.

Discussants:

Dr. Richard D. Moore.....Medical Records
Dr. Leon E. Mermod.....Blood and Blood Bank
Dr. Ralph B. Cloward....Operating Room and Wards
Mr. Frank B. Gibson......"Res Locquicure"
Mr. Moon Chang.....Hospital and Personnel Liability
Mr. Hyman M. Greenstein.....Why Malpractice Suits
Gen. J. W. Schwartz.....Federal Hospitalization

Moderator: Mr. R. M. Kennedy
Alternate: Mr. Bill Fleming

Dr. Richert welcomed Drs. Masaru Koike, Victor M. Mori, and Lawrence Y. W. Wong into the Society as active members.

Dr. Richert announced that a Life Membership has been awarded Dr. Clifton S. Culpepper who has been a member of the Medical Society since 1923.

In memory of Dr. J. Warren White, a resolution was read by Dr. Edwin Chung-Hoon and was adopted by the Society by a rising vote. A minute of silence was observed by the membership in memory of Dr. White.

Dr. Richert reported that the Board of Governors ha accepted the report of the Medical Practice Committee namely that, "the manner in which fees are charge and the remuneration of doctors in partnerships, groups and clinics in our community, do not violate the ethica principles of the AMA." The committee, he stated, base its findings on correspondence with the Judicial Counci of the AMA. He further stated that the entire file an correspondence on this matter was available to the mem bership in the Medical Society's office.

Dr. Richert stated that the Board of Governors ha gone on record as approving the Commission's proposa of a three-year program in postgraduate clinical psychi atry for Honolulu. He briefly reviewed the Commission' plan for picking a psychiatrist from Hawaii and send ing him to the mainland for a course in teachin methods. He would then return to Hawaii to take o small groups of 10 to 12 as trainees. Funds for this train ing program would be supplied by the Western Inte state Commission for Higher Education.

Dr. Richert announced that Dr. Nils P. Larsen wil be the Society's official representative to the Inte Science Education Council and that Dr. Clarence E Fronk will serve as alternate.

Mr. Kennedy reported that our insurance advisor ha informed us that the Society has received to date onl 76 applications for its Group Life Insurance Plan. 30 applicants or 75% of the doctors is needed in order t initiate the plan. He has also advised us that if th Society fails in this attempt to get sufficient enrollmen probably no other insurance company will consider th group again. Another brochure will be sent out in th mail shortly explaining the plan in detail and urgin the doctors to participate if they have not already don so.

A progress report by Dr. Richert revealed that so fa 76 doctors have contributed to the Chest; this is ap proximately 35% of the Society's goal. The docto were urged to send in their contributions to the Socie so that the Society could receive credit for it.

Dr. Caver, chairman of the Public Service Committe reported that the *Honolulu Advertiser* has proposed joint sponsorship of a series of medical forums. H stated that the panel would be composed of doctors an the subjects they would discuss would be of particul interest to the community. He then invited the mem bership to send in suggested topics for these forum and briefly mentioned a few topics of interest.

A. S. HARTWELL, M.D.
Secretary


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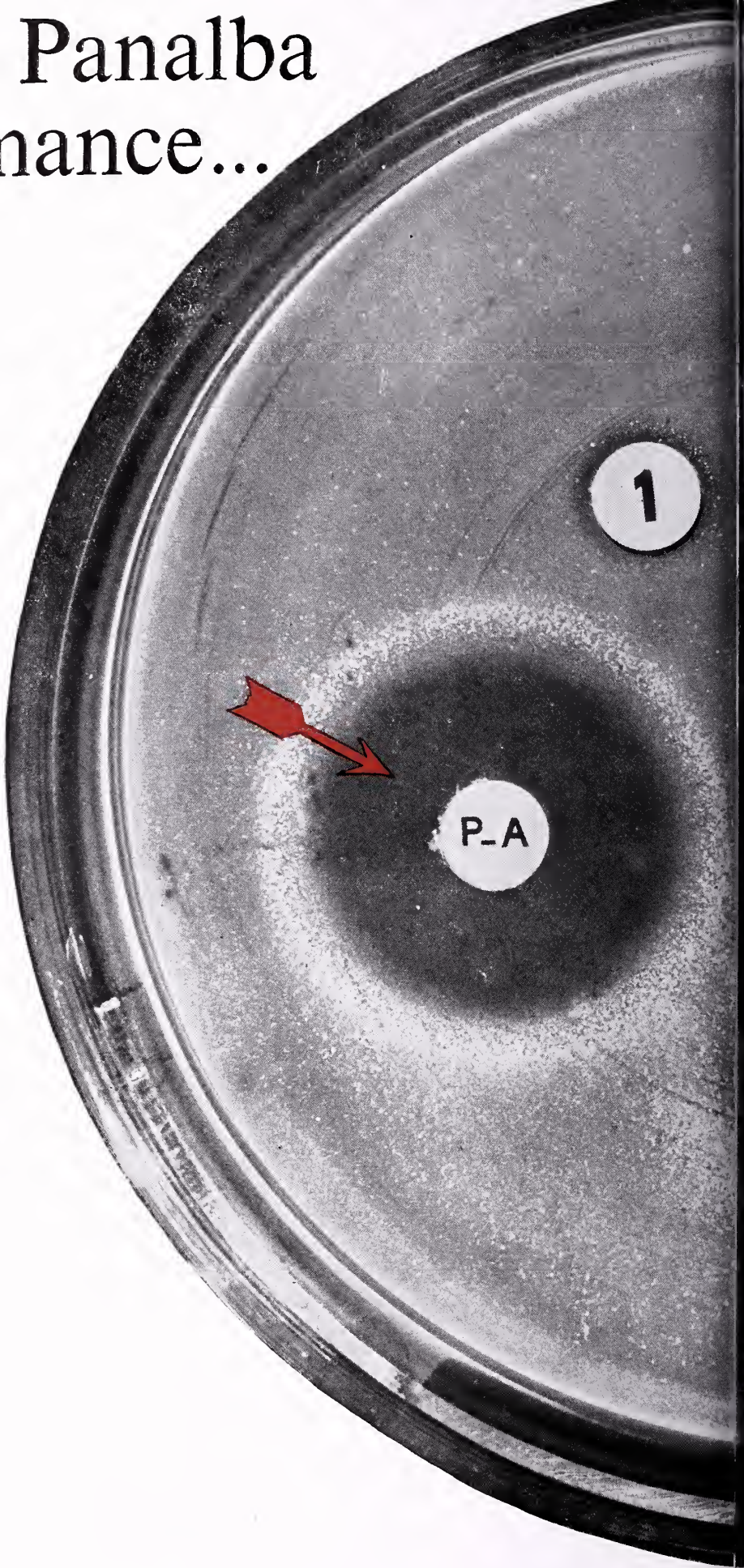
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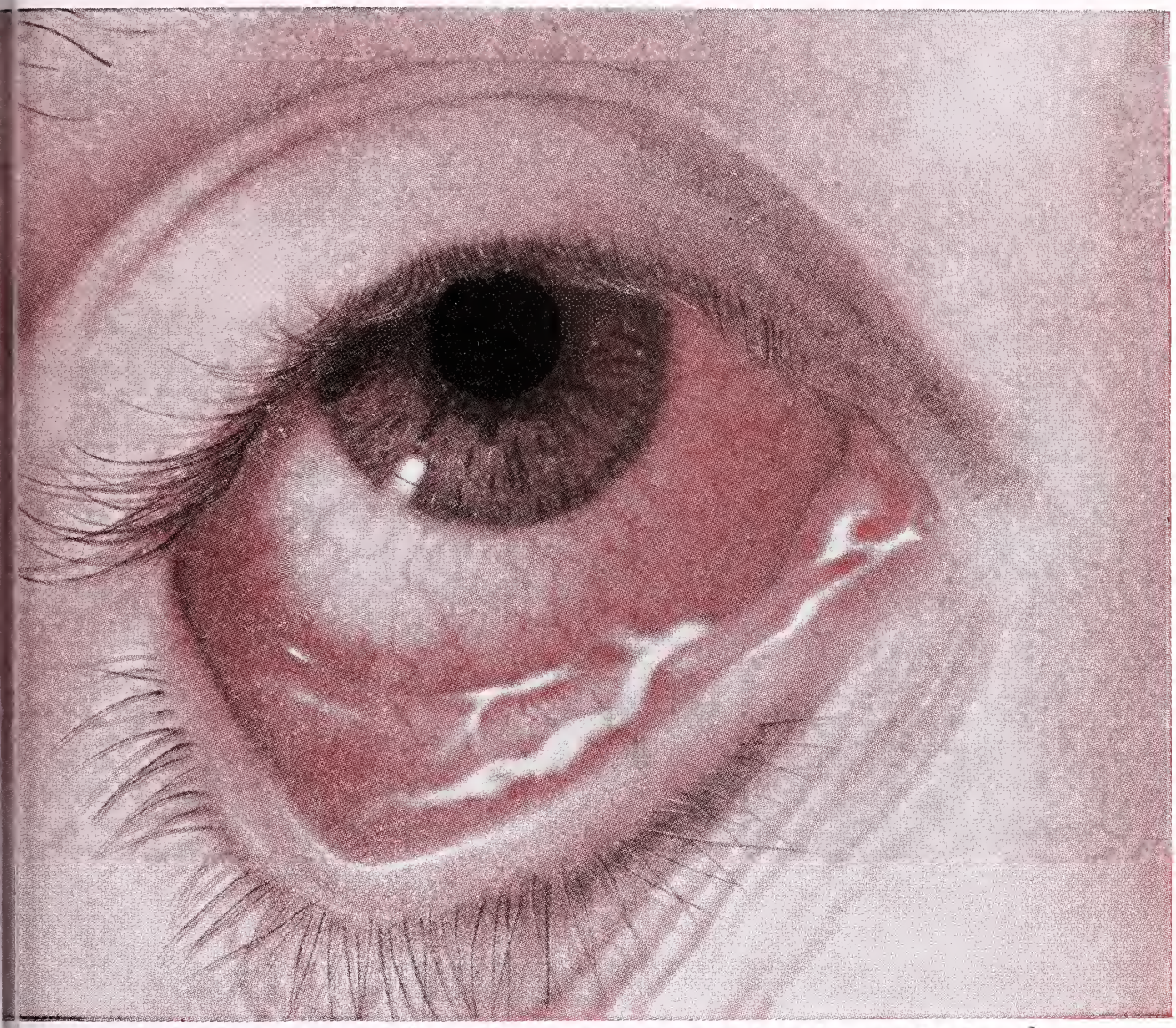
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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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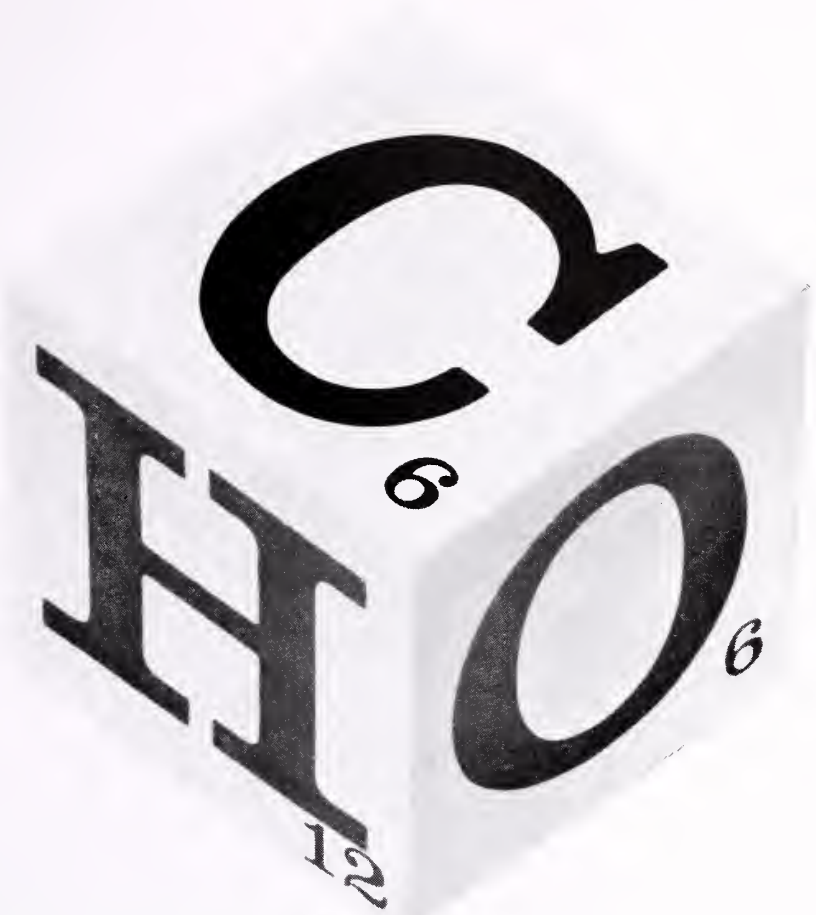
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Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
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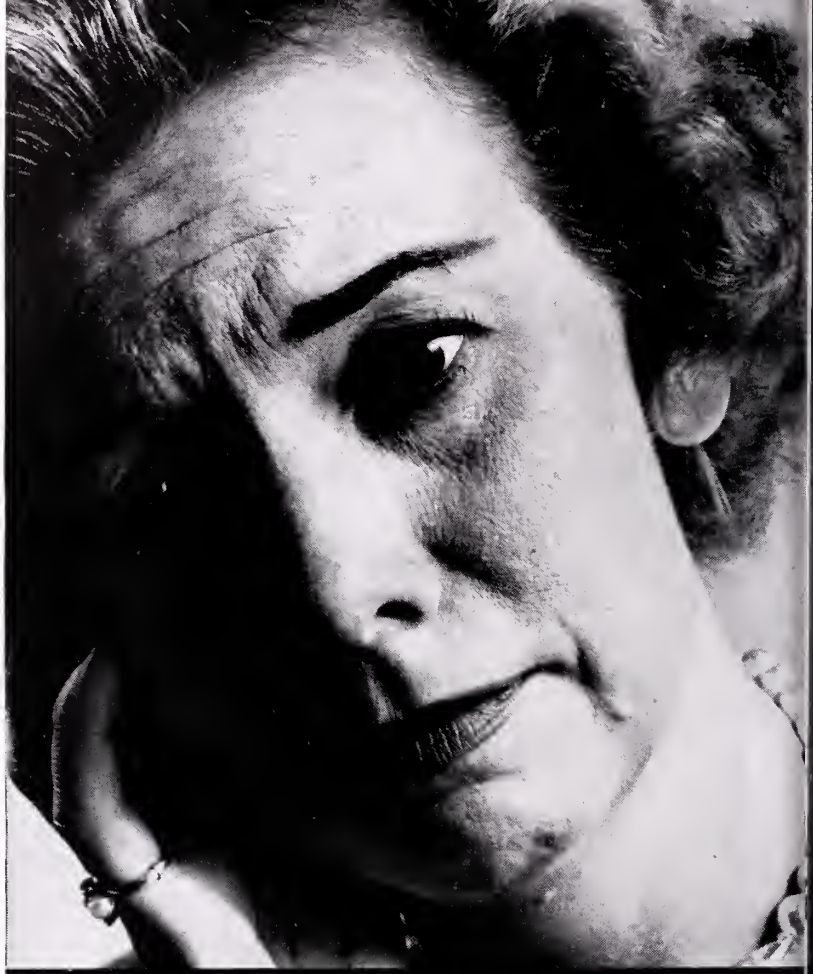
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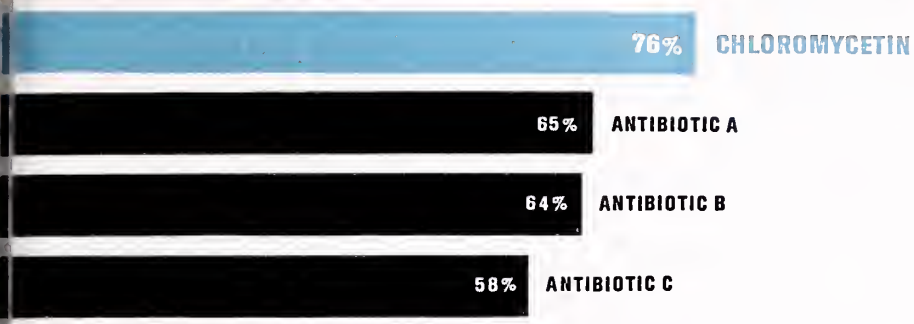
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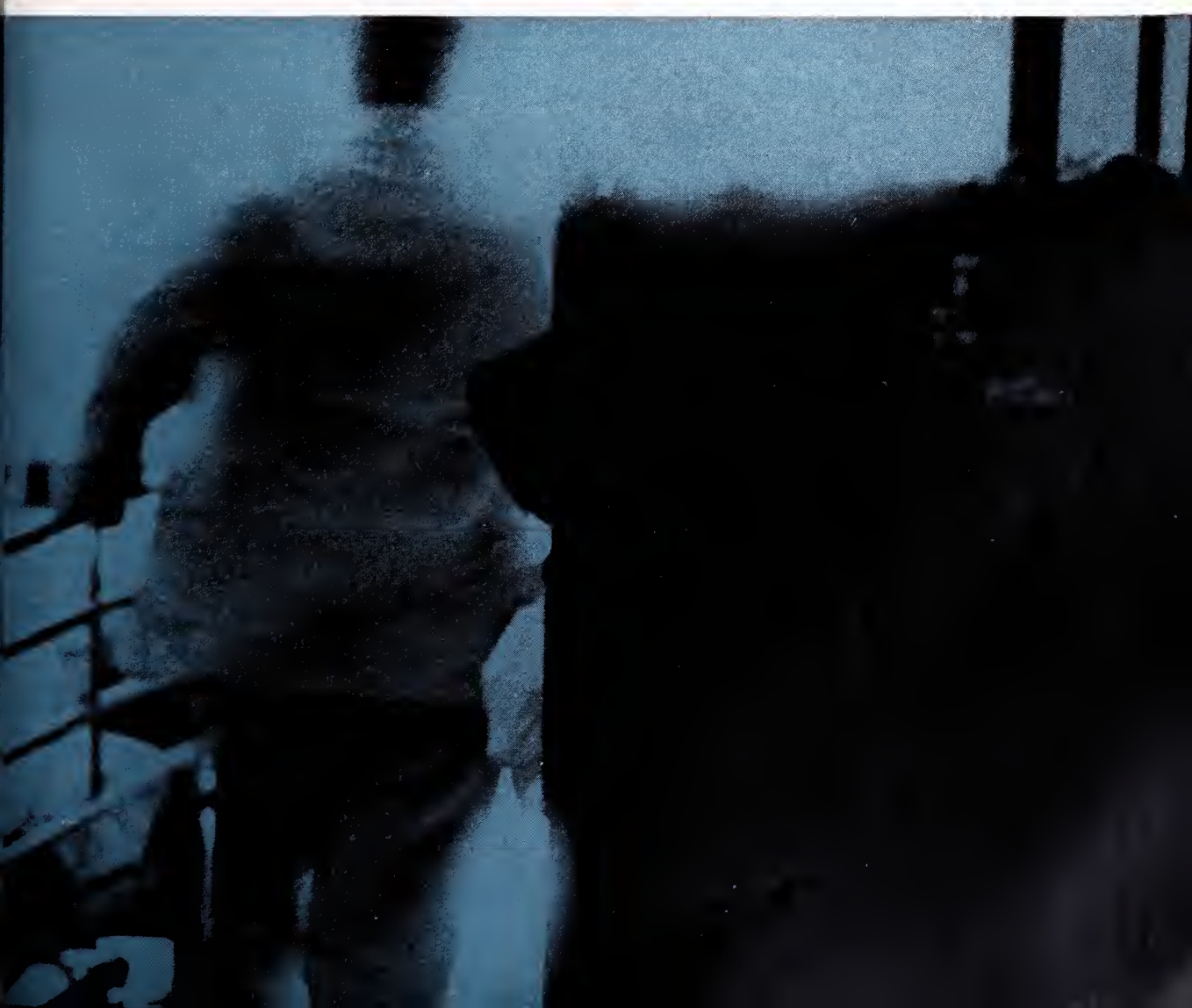


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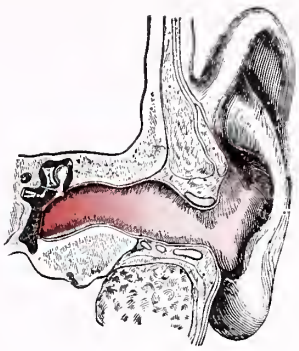
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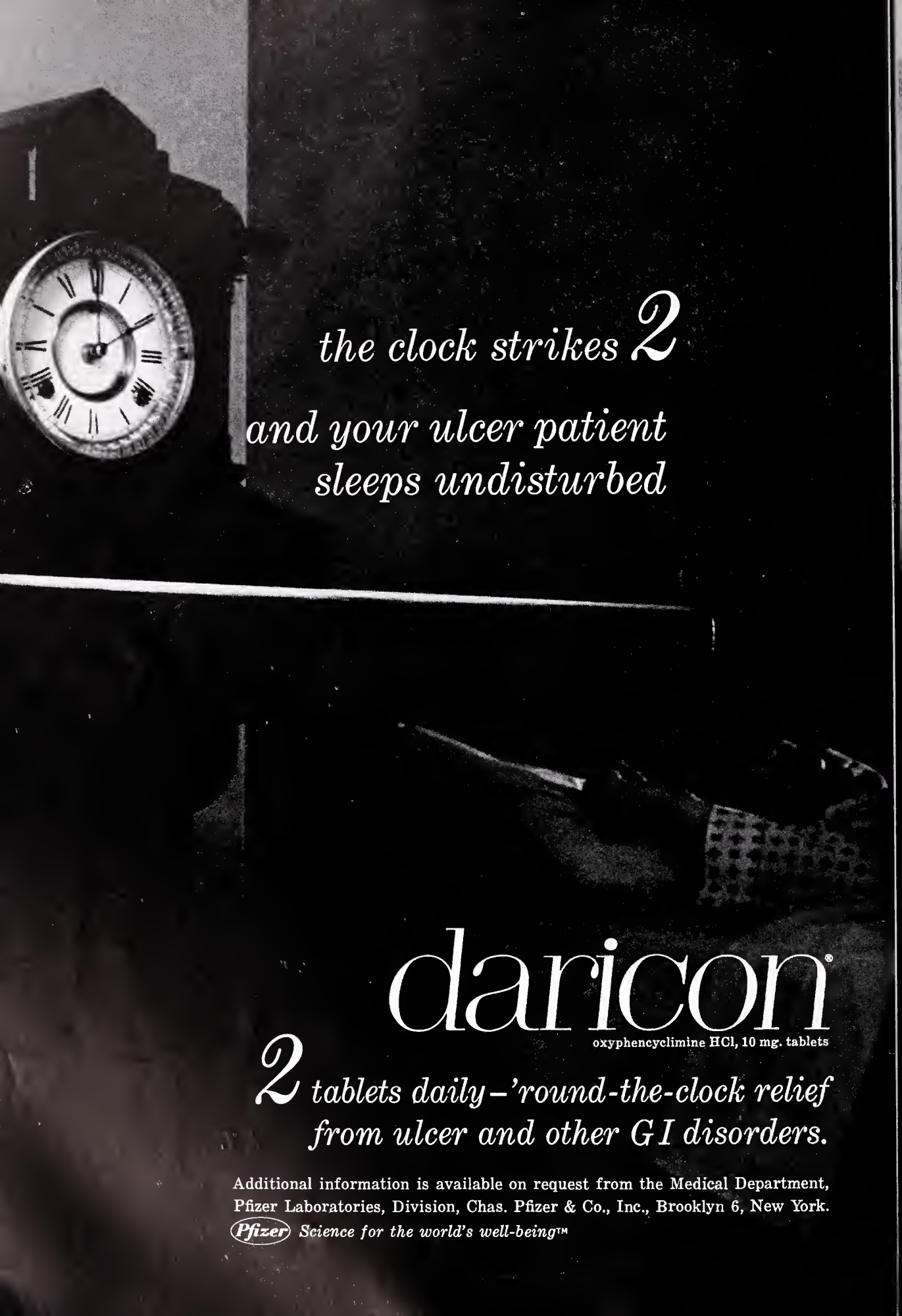
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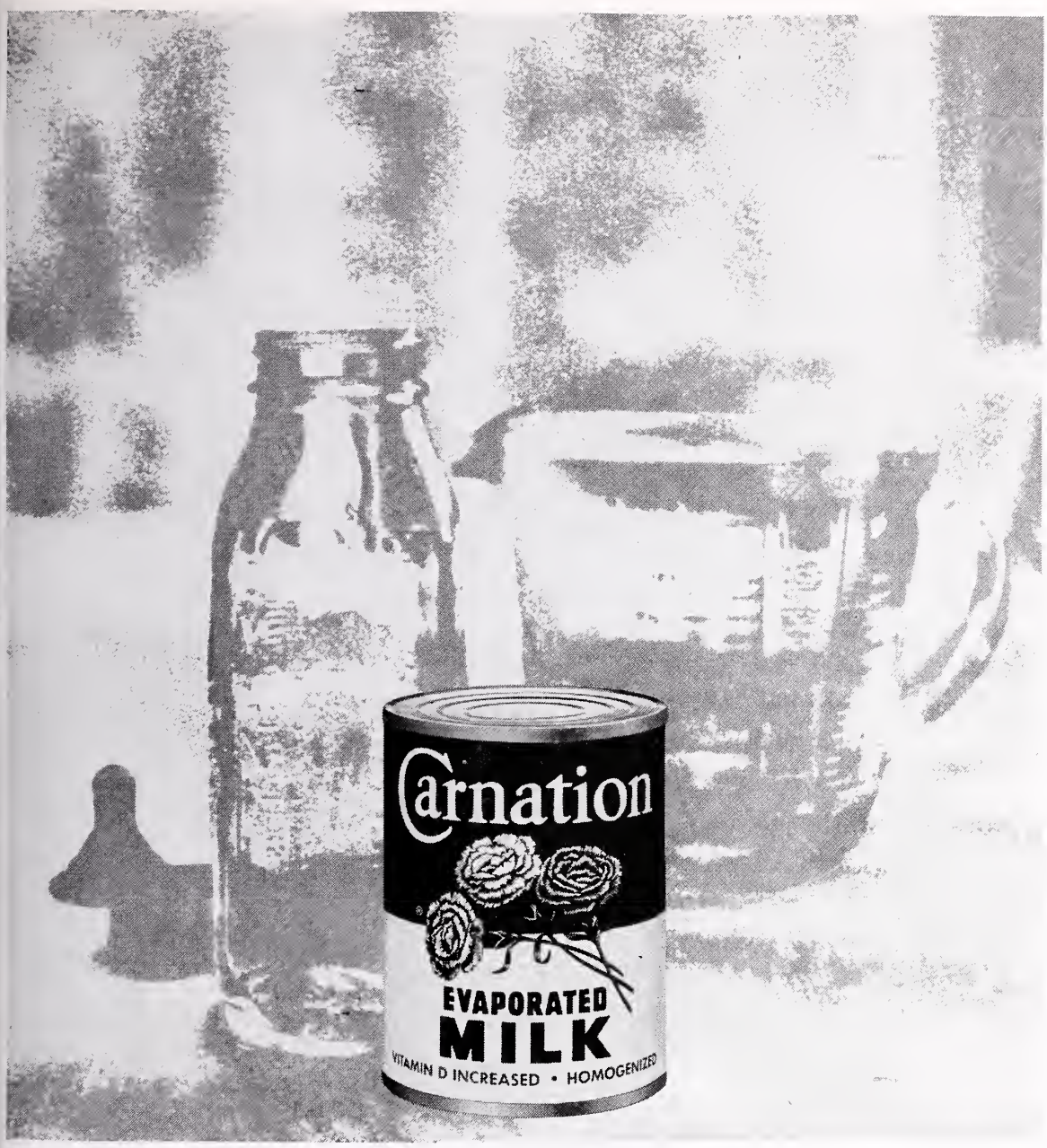
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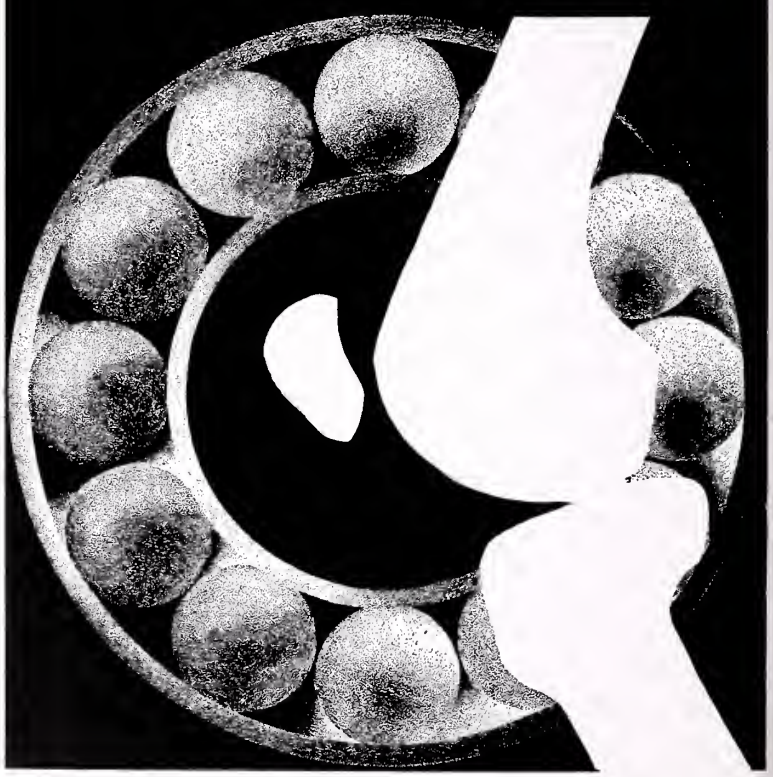
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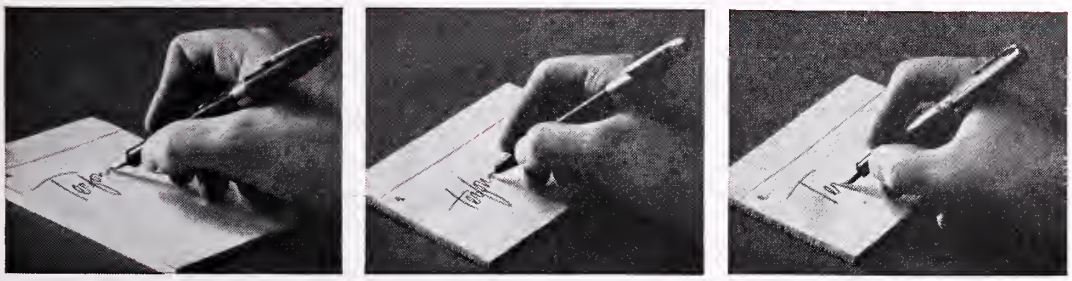


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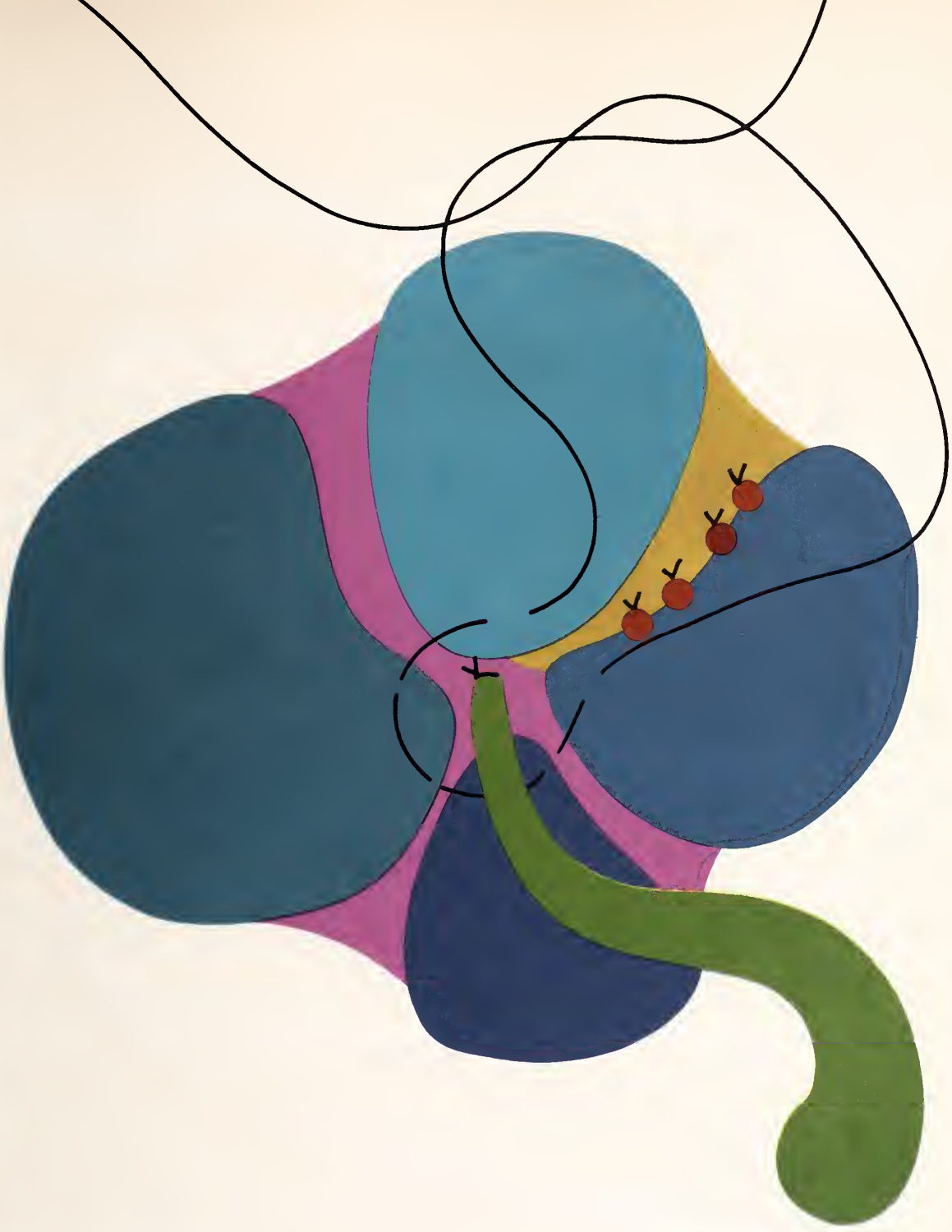


BAD DIGESTION INCLINES ONE TO SKEPTICISM, INCREDULITY, BREEDS BLACK FANCIES AND THOUGHTS OF DEATH JOSEPH CONRAD

When bad digestion is the consequence of digestive enzyme deficiency, Entozyme may dispel drear symptoms such as pyrosis, flatulence, belching, and nausea, for it is a natural supplement to digestiv enzymes. It provides components with digestive enzyme activity: **Pepsin,** N. F., 250 mg., **Pancreatin,** N F., 300 mg., and **Bile Salts,** 150 mg. Because Entozyme is actually a tablet-within-a-tablet, these com ponents are freed in the physiological areas where they occur naturally. Entozyme has proved useful i relieving many symptoms associated with cholecystitis, post-cholecystectomy syndrome, sub-total gas trectomy, pancreatitis, infectious hepatitis, and a variety of metabolic diseases.

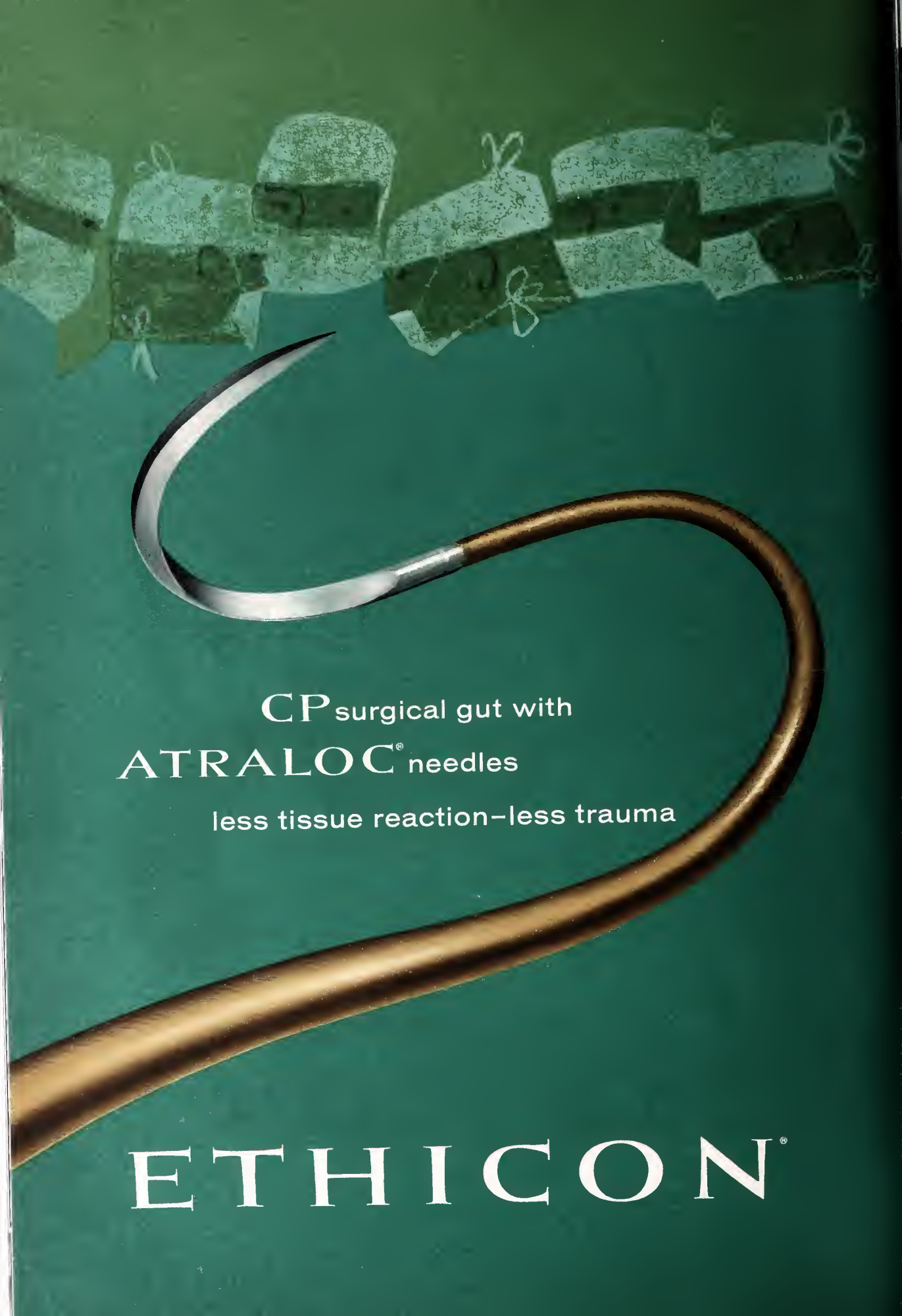
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advancing with surgery

ETHICON®



CP surgical gut with
ATRALOC® needles
less tissue reaction–less trauma

ETHICON®

IN MANY CASES: ENDS THE NEED FOR PAINFUL PENICILLIN INJECTIONS

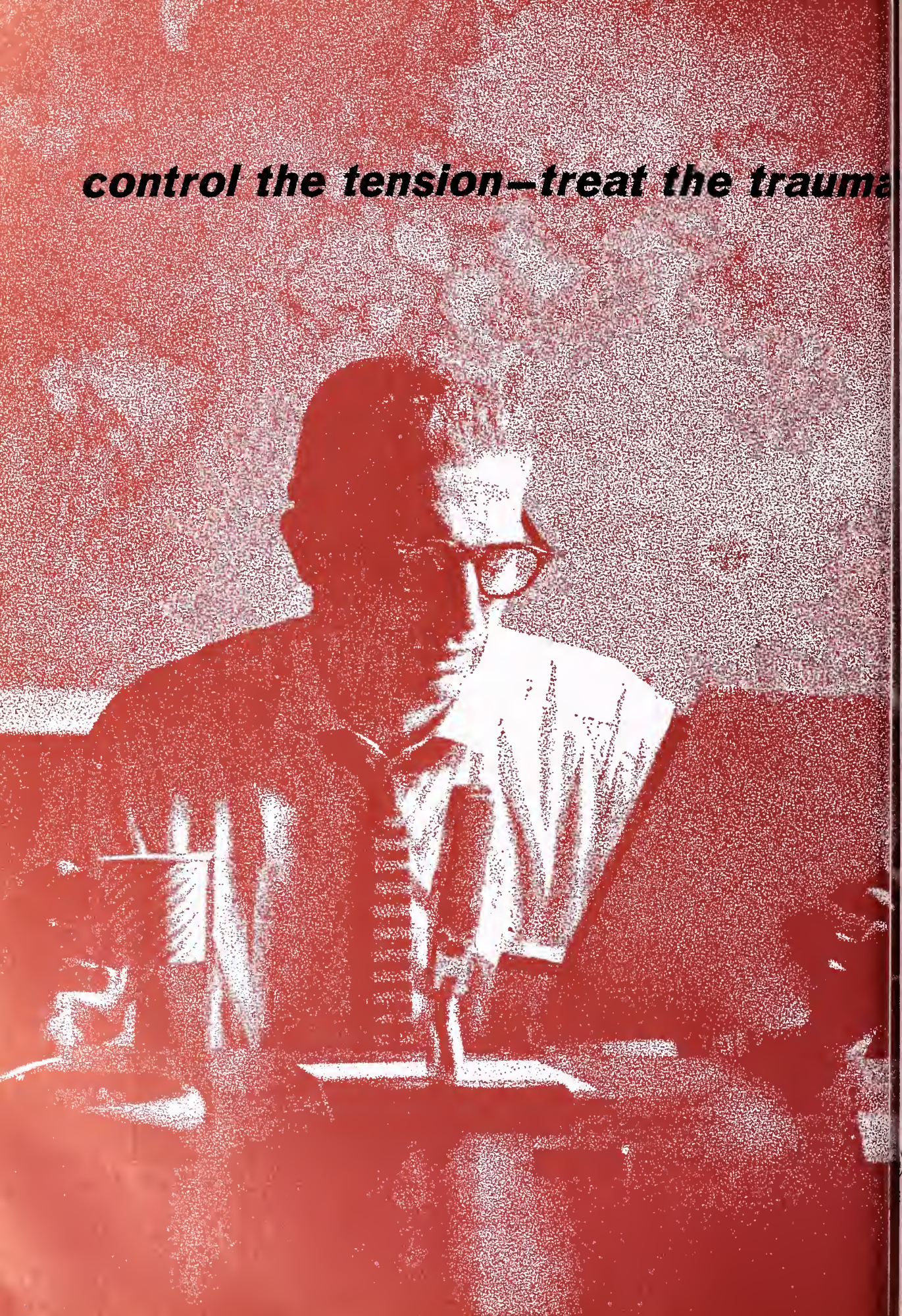
COMPOCILLIN®-VK
(POTASSIUM PENICILLIN V, ABBOTT)
OFFERS THE HIGH BLOOD LEVELS OF POTASSIUM PENICILLIN V



Available in tiny, easy-to-swallow Filmtabs® and in tasty, cherry-flavored Oral Solution.
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®FILMTAB—FILM-SEALED TABLETS, ABBOTT.


control the tension–treat the trauma

Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

mebrobamate (400 mg. or 200 mg.) widely accepted tranquilizer and . . .

PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.

PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

LE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



SYMPOSIUM REPORT:

ALTAFUR in surgical (soft tissue) infections

In a series of 159 patients with various types of surgical infections (cellulitis, abscess, wound infections), ALTAFUR was employed with eminently satisfactory results. The incidence and magnitude of surgery were considerably reduced in these cases, and when surgical intervention was necessary it could be delayed until the inflammatory process had receded or become localized.

Excellent therapeutic response was obtained in patients with infections due to coagulase positive Staphylococcus aureus, beta hemolytic Streptococcus, and Escherichia coli; these organisms were uniformly susceptible to ALTAFUR in vitro. An insensitive strain of Pseudomonas aeruginosa was isolated from the single patient who failed to respond. ALTAFUR was given orally to 150 patients, the majority receiving 100 mg. four times daily.* Duration of treatment ranged from 4 to 30 days, averaged 6 days. An experimental intravenous preparation of ALTAFUR was administered to 9 patients who could not take medication by mouth or whose condition warranted exceptionally high dosage. There was no clinical or laboratory evidence of toxicity in any case, and ALTAFUR was well tolerated by all but 1 of the 159 patients.

Prigot, A.; Felix, A. J., and Mullins, S.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, September 12, 1959 (published Nov. 1959)

*Experimental dosage (see dosage recommendations adjacent)

bright new star

in the antibacterial firmament

ALTAFUR™

brand of furaltadone

the first nitrofuran effective orally

in systemic bacterial infections

- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
- Decisive bactericidal action against staphylococci, streptococci, pneumococci, coliforms
- Sensitivity of staphylococci in vitro (including antibiotic-resistant strains) has approached 100%
- Development of significant bacterial resistance has not been encountered
- Low order of side effects
- Does not destroy normal intestinal flora nor encourage monilial overgrowth (little or no fecal excretion)

Tablets of 50 mg. (pediatric) and 250 mg. (adult)
Average adult dose: 250 mg. four times a day, with food or milk
Pediatric dosage: 22-25 mg./Kg. (10-11.5 mg./lb. body weight daily in 4 divided doses

CAUTION: The ingestion of alcohol in any form, medicinal or beverage, should be avoided during Altafur therapy.

NITROFURANS—a *unique* class of antimicrobials
EATON LABORATORIES, NORWICH, NEW YORK

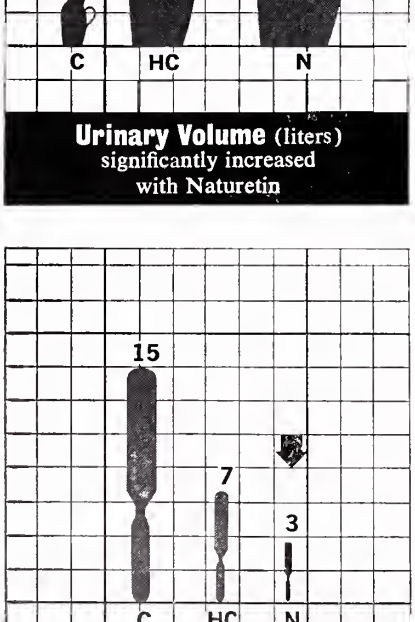
more closely approaches the ideal diuret

Naturētin

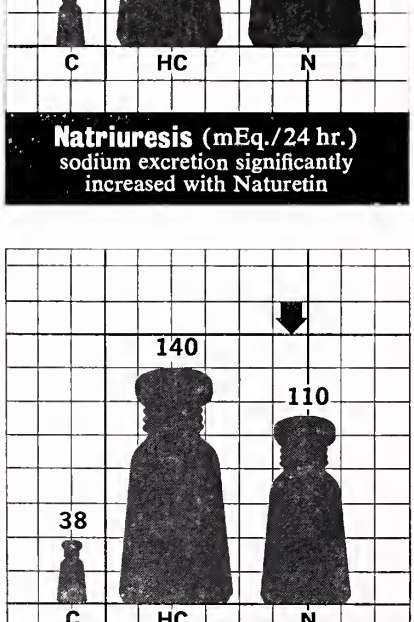
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic
of compounds, this drug [NATURETIN] shows a significar
creased natriuresis and decreased loss of potassium and
bonate. In this respect it more closely approaches a nat
'ideal diuretic.' It is effective upon continuous administrati
causes no significant serum biochemical changes. It is e
in a wide variety of edematous and hypertensive stat
represents a significant advance in diuretic therapy." *Fora*
Pharmacological observations on a more potent benzothia
diuretic; accepted for publication by the American Heart J

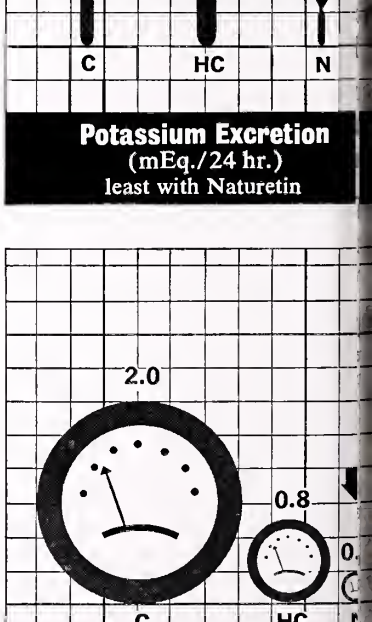
Comparison of electrolyte excretion pattern for the 24 hours follow
typical doses of chlorothiazide, hydrochlorothiazide, and Naturet



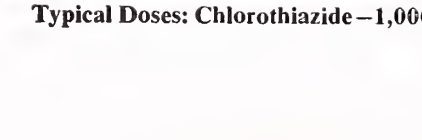
Urinary Volume (liters)
significantly increased
with Naturetin



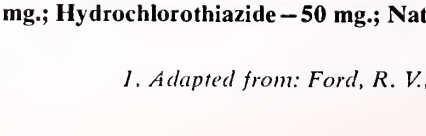
Natriuresis (mEq./24 hr.)
sodium excretion significantly
increased with Naturetin



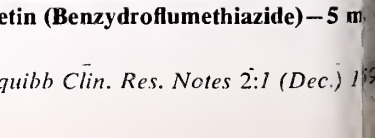
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 m

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 1

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

Contraindications: none, except in complete renal shutdown.

Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, veratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all preparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous drop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin regimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on digitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—nausea or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

Naturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

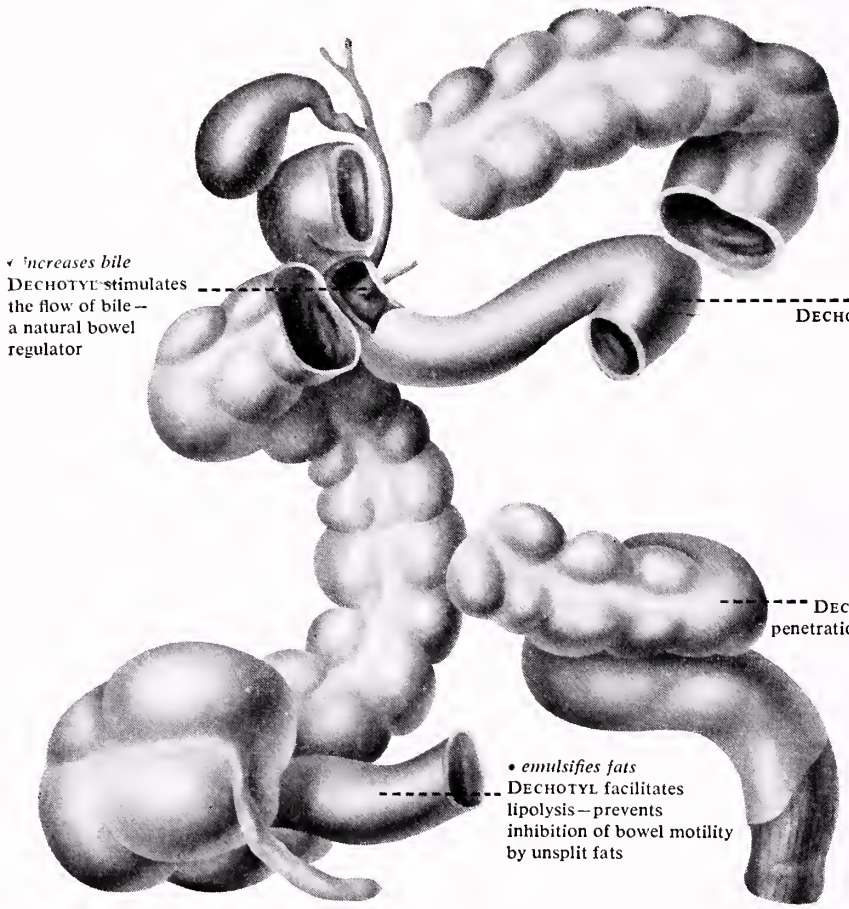
Naturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

SQUIBB

Squibb Quality—the Priceless Ingredient

℞ Naturetin 5mg. #30 Disp. Sig: 1 each morning

'RAUDIXIN'® AND 'NATURETIN' ARE SQUIBB TRADEMARKS.



helps free your patient from both... constipation and laxatives

DECHOTYL®

TRABLETS*

well tolerated...gentle transition to normal bowel function



Recommended to help convert the patient—naturally and gradually—to healthy bowel habits. Regimens of one week or more are suggested to assure maintenance of normal rhythm and to avoid the repetition of either laxative abuse or constipation.

Average adult dose: Two TRABLETS at bedtime as needed or as directed by a physician. *Action usually is gradual, and some patients may need 1 or 2* TRABLETS *3 or 4 times daily.*

Contraindications: Biliary tract obstruction; acute hepatitis.

DECHOTYL TRABLETS provide 200 mg. DECHOLIN,® (dehydrocholic acid, AMES), 50 mg. desoxycholic acid, and 50 mg. dioctyl sodium sulfosuccinate, in each trapezoid-shaped, yellow TRABLET. Bottles of 100.

*AMES T.M. for trapezoid-shaped tablet.

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COMPANY, INC
Elkhart • Indiana
Toronto • Canada

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for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

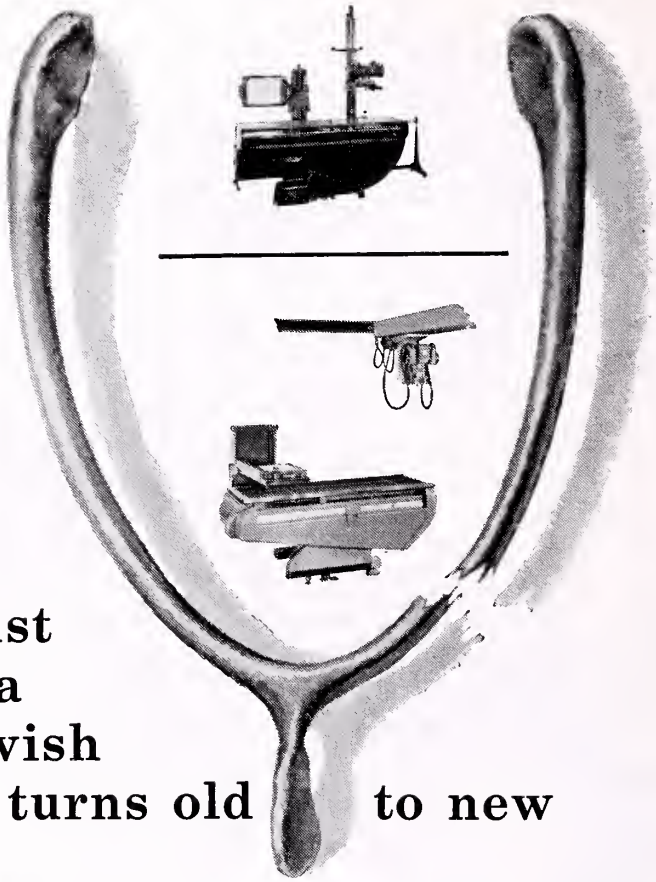
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*–400 mg. *unmarked,* coated tablets.

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meprobamate (Wallace)

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IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available — for greater flexibility in dosage — PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

Endo®

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

*U.S. Pat. 2,628,185

Tofrānil®

brand of imipramine HCl

in depression

lights the road to recovery in 80 per cent of cases

In the treatment of depression Tofrānil has established the remarkable record of producing remission or improvement in approximately 80 per cent of cases.[1-7]

Tofrānil is well tolerated in usage—is adaptable to either office or hospital practice—is administrable by either oral or intramuscular routes.

Tofrānil
a potent thymoleptic . . .
not a MAO inhibitor.

Does act effectively in *all* types of depression regardless of severity or chronicity.

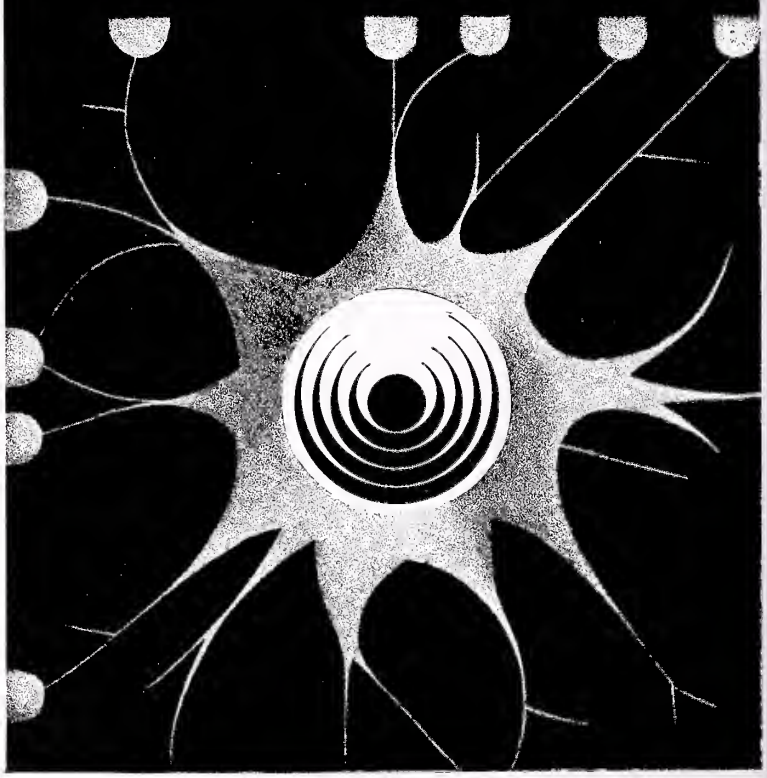
Does not inhibit monoamine oxidase in brain or liver; produce CNS stimulation; or potentiate other drugs such as barbiturates and alcohol.

Detailed Literature Available on Request.

Tofrānil® brand of imipramine HCl: tablets of 25 mg., bottles of 100. Ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution, cartons of 10 and 50.

References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

Geigy, Ardsley, New York

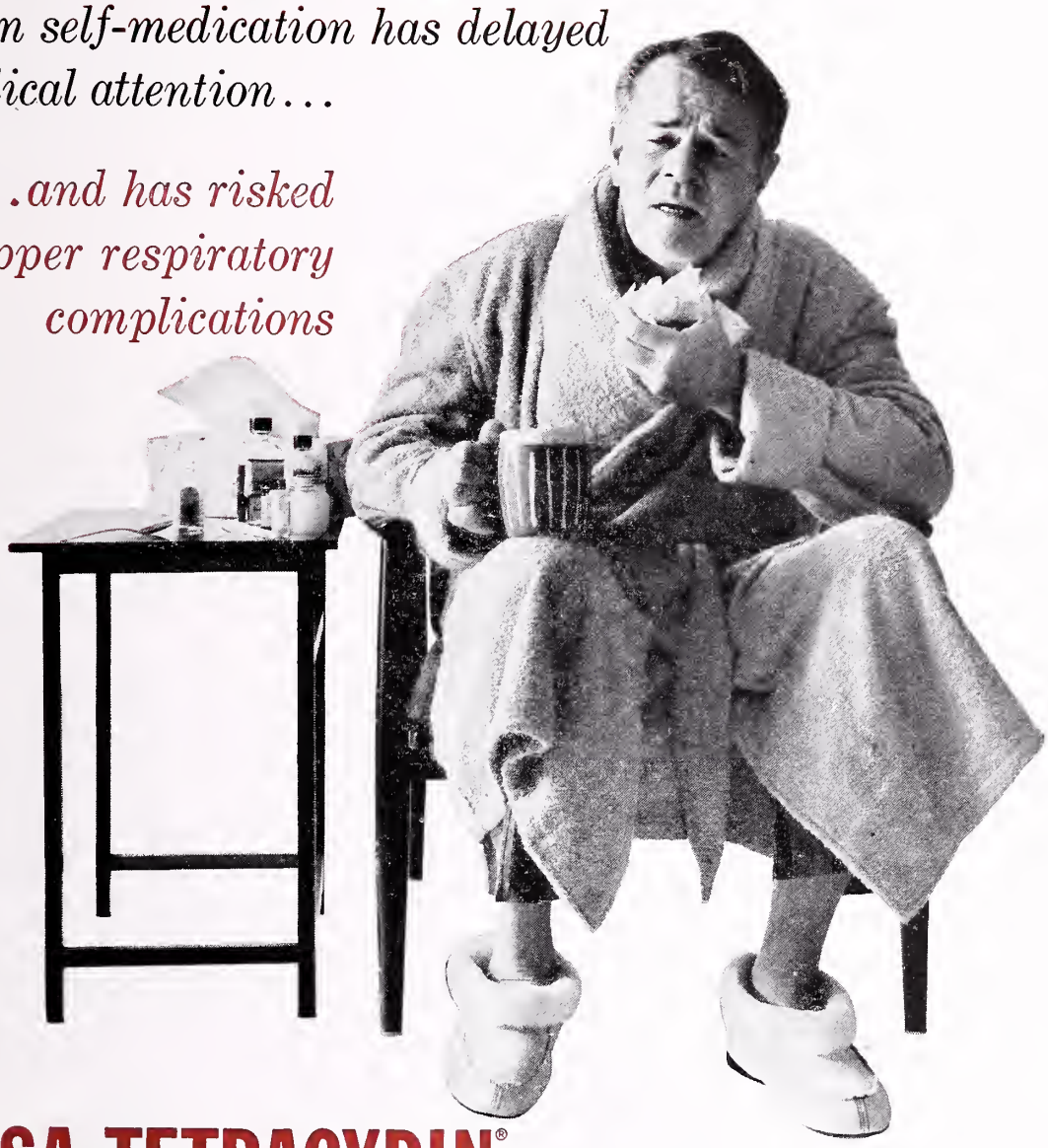


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TO4-60

in the **"COMMON COLD"**
when self-medication has delayed medical attention...

...and has risked upper respiratory complications



COSA-TETRACYDIN® CAPSULES

Cosa-Tetracyn® — analgesic — antihistamine compound

act quickly to

- *control secondary infection*
- *alleviate cold symptoms*

each capsule contains:

Cosa-Tetracyn	125 mg.
phenacetin	120 mg.
caffeine	30 mg.
salicylamide	150 mg.
buclizine HCl	15 mg.

average adult dose: 2 capsules q. i. d.

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.*

The first synthetic penicillin available for general clinical use

FOR YOUR NEXT PATIENT WHERE PENICILLIN IS INDICAT

SYN

BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARIT





NSIDER THESE 6 IMPORTANT THERAPEUTIC BENEFITS OF

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NTIBIOTIC
CTIVITY
LRECTLY
ROPORTIONAL
O ORAL DOSE

REDUCED
RATE OF
INACTIVATION
BY STAPH
PENICILLINASE

MANY STAPH
STRAINS MORE
SENSITIVE TO
SYNCILLIN
IN VITRO

BRISTOL





FOR HIGHLY EFFECTIVE THERAPY OF THE LARGE VARIETY OF INFECTIONS CAUSED BY SUSCEPTIBLE PATHOGENS...NEW

SYN

Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity.*

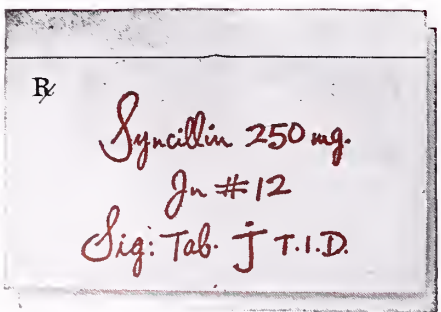
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

L L I N™

Relation of intermittent blood levels YNCILLIN ntibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations. the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

luced rate of inactivation YNCILLIN by staph enicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.

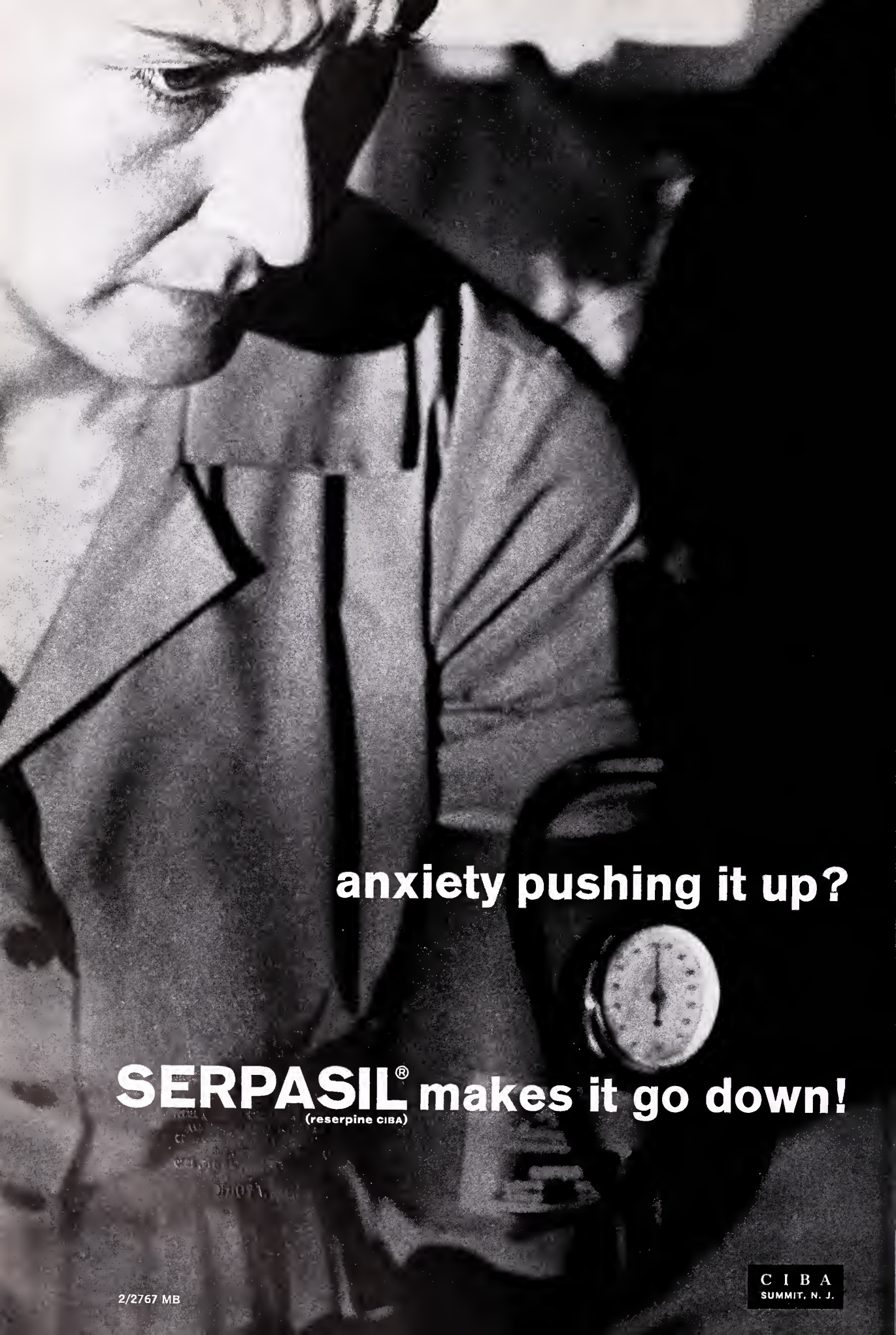
Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, 1959, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Eagle, H. and Musselman, A. D.: J. Bact. **58**:475, 1949.

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anxiety pushing it up?
SERPASIL®
(reserpine CIBA)
makes it go down!
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SUMMIT, N. J.

Incremin®

Lysine-Vitamins Lederle

with iron Syrup

for the undersized underweight child



build appetite

with
B complex
vitamins

prevent nutritional anemia

with ferric pyrophosphate, a form of iron exceptionally well-tolerated

promote protein uptake

with the potentiating effect of l-Lysine on low-grade protein foods

in taste-tempting cherry flavor

Average dosage, 1 teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
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Wine Aids Gastric Digestion—Ogden and Southard[2] reported a significant increase in gastric secretion following ingestion of moderate amounts of table wine.

Wine Helps in Cardiology—Prudent quantities of wine are helpful[3] in counteracting depression, anxiety and discomfort in sufferers from heart and coronary disorders.

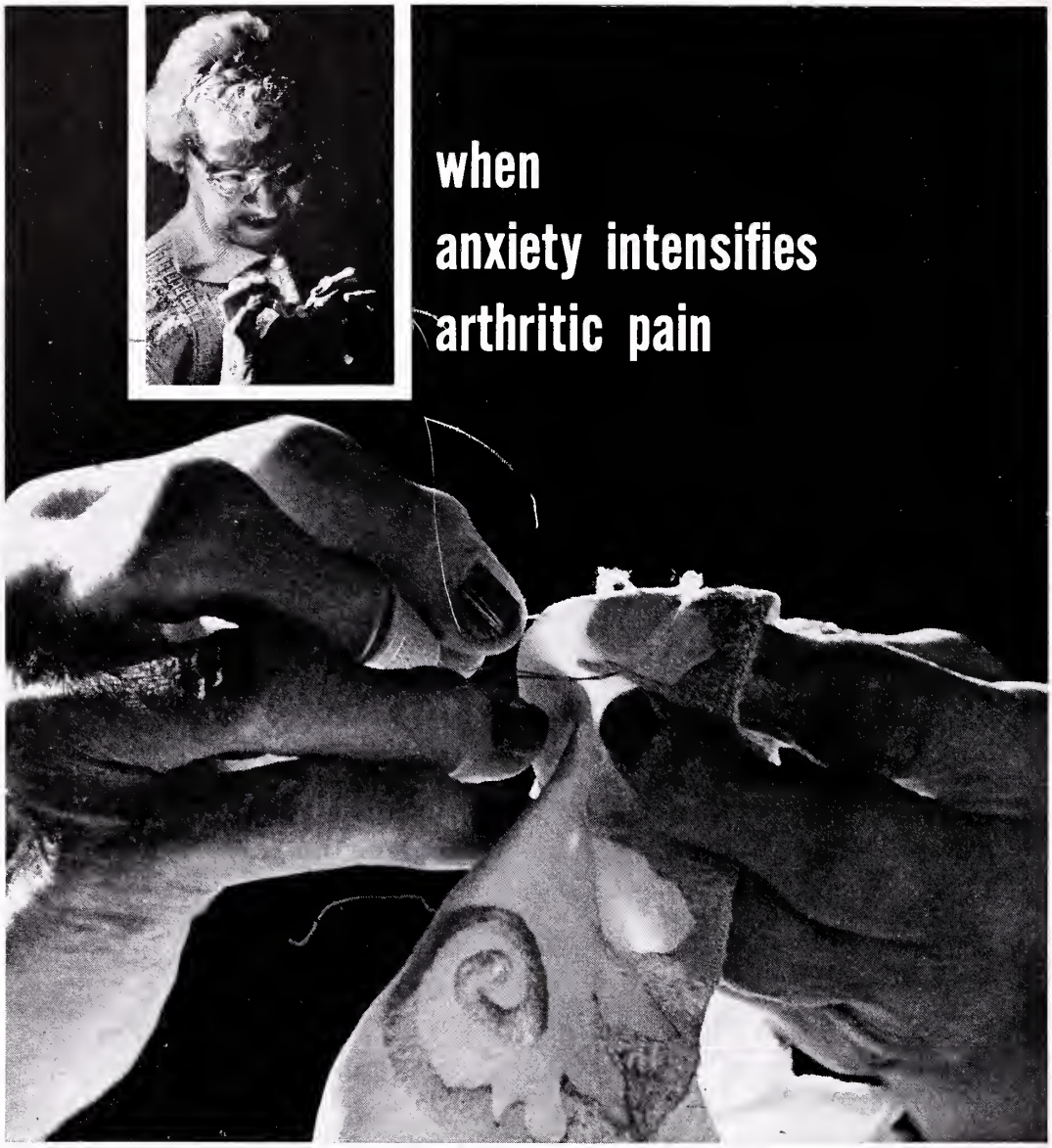
Wine—"safest of all sedatives..."[4]—A little Port or Sherry at bedtime offers a valuable relaxant to the insomniac and may obviate the need for drug-sedative medication.

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Research information on wine is available on request. Write for your copy of *"Uses of Wine in Medical Practice." Wine Advisory Board, 717 Market Street, San Francisco 3, California.

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1. Gaetzl, F.R.: Permanente Faund. M.Bull. *8*:72 (April) 1950.
2. Ogden, E., and Southard, F.D., Jr.: Fed. Praceedings *5*:77 (1946)
3. Braaks, H.: Med. J. & Rec. *127*:199 (1928)
4. Haggard, H.W., and Jellinek, E.M.: Alcahal Explored, New Yark, Doubleday, Doran, 1942.



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020407

Children born to leprous mothers seem safe from infection if removed from contact at birth

Leprosy in Children Born at Kalaupapa

ROBERT M. WORTH, M.D., M.P.H., Berkeley, California

HAWAII PRESENTS a fertile field for retrospective studies of leprosy, because it has had a fairly high prevalence of the disease in the recent past, it is geographically isolated, and it has had a rather thorough case-finding program for the past seven or eight decades, with good demographic and disease records available for the same period. The same cannot be said for most other areas of the world where leprosy has been present to any considerable degree during the past half-century.



DR. WORTH

From 1880 to 1949 there were recorded 642 births to patients at Kalaupapa Settlement, the leprosy isolation settlement on Molokai. One or both of the parents of almost every one of these infants had active lepromatous leprosy at the time of the birth, and it is of historical and epidemiologic interest to trace the changing methods of caring for these children, and the changing incidence of subsequent leprosy in them.

A review of studies begun by the late Dr. W. Lloyd Aycock, Professor of Preventive Medicine, Harvard Medical School.

Received for publication Oct. 25, 1959.

Methods

At the invitation of the Territorial Board of Health, the late Dr. W. Lloyd Aycock, then Professor of Preventive Medicine at Harvard Medical School, visited Hawaii briefly in 1948, 1949, and 1950. In cooperation with the Bureau of Health Statistics and the Division of Hansen's Disease Dr. Aycock undertook three separate analyses of leprosy in Hawaii: 1) a general historical review, 2) a genealogical study of several patients, and 3) the history of 642 children born at Kalaupapa between 1880 and 1949, inclusive. These studies were found in incomplete form among Dr. Aycock's papers after his death in 1951. They came into the possession of the author while he was a student at the Harvard School of Public Health in 1957, and the data of part 3 are presented in expanded form here, with analysis and conclusions added by the author.

Information on the history of child-rearing practices at Kalaupapa has been obtained from some of the older patients there, through the cooperation of Sister Roseanne, Nursing Supervisor at Kalaupapa Hospital.

Infant Mortality Was High

The data gathered by the Bureau of Health Statistics show a rather high infant mortality rate (nearly 200 per 1000 live births) among the 642 children born at Kalaupapa from 1880 to 1949.

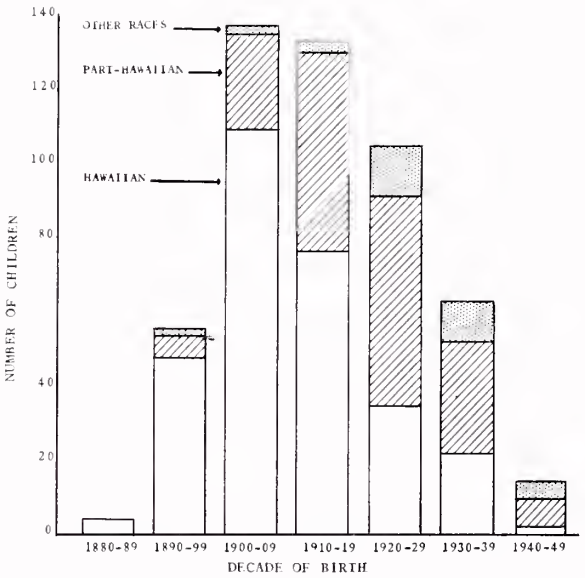


Fig. 1. Race and Decade of Birth of 505 Children Surviving Infancy Born at Kalaupapa 1880-1949.

This is a commentary on the status of sanitation and infant care during the era when most of these children were born (prior to 1930). Approximately 505 of these children survived the first year of life, and therefore lived long enough to be counted as running the risk of developing clinically recognizable leprosy.

Figure 1 defines this "population at risk" in terms of race and decade of birth. The data from 1866 (the year of establishment of Kalaupapa) to 1879 are incomplete and were therefore excluded from this study. The data for the decade 1880-89 are of questionable reliability, but from there on the records are fairly adequate. The falling number of births in recent decades roughly parallels the falling population at Kalaupapa, accentuated somewhat in recent years by the policy of exclusion of non-infected spouses from the hospital. The racial distribution roughly follows the racial composition of the patients.

Most of these 505 children were under direct medical surveillance for at least a decade after leaving Kalaupapa, and virtually all of them lived their entire lives in the Territory, where it is rather difficult for a case of leprosy to go undiagnosed or unreported for very long, thanks to the alertness of our practicing physicians and to the persistence of our Health Department's case-finding program.

Attack Rate Parallels Policies

Figure 2 shows the incidence of subsequent leprosy in these children by race and by decade of birth (a total of 69 cases). The number of part-Hawaiian children born in the decade 1890-99 is too small for the rate to be reliable, but the other rates after 1889 are fairly secure and show a high level (42%) of infection prior to 1900, a plateau of about 8-15% from 1900 to 1929, and none thereafter.

The break-points in this graph coincide fairly well with policy changes in the handling of children born in the settlement. Prior to 1903, approximately, the newborn infants stayed at home with their parents from birth until they were removed from Kalaupapa for adoption or for placement in the "preventoria" operated in Honolulu by the Health Department (for boys) and the Sisters of St. Francis (for girls). In practice, this meant that the infants stayed with their parents at least until weaned, if not longer. The high incidence of subsequent disease in the surviving children from this group corresponds roughly with what Lara[1] found (36%) in 127 children living with their parents at Culion Colony in the Philippines. The fact that even after these conditions of maximal exposure approximately 60% of the children failed to come down with recognizable leprosy certainly lends support to the view that the resistance of the individual has a great role to play in the epidemiology of this disease, or that there are many cases of subclinical leprosy which are never diagnosed by our present methods of observation, or both.

Isolation Lowered Incidence

The plateau of rates in those children born between 1900 and 1929 shows no reliable difference between Hawaiians and part-Hawaiians. It corresponds with a period (beginning about 1903), during which it was the policy to remove the infants from their mothers at birth and to place them in a nursery at Kalaupapa until they were

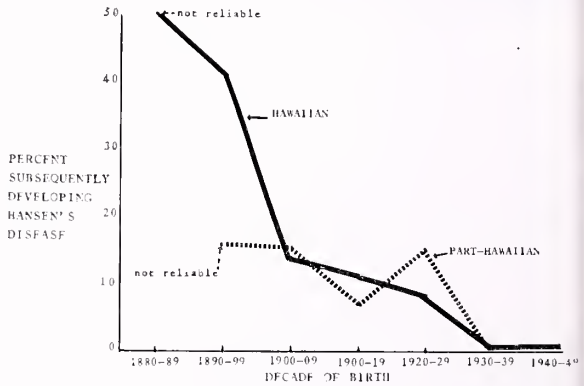


Fig. 2. Leprosy Attack Rate by Decade of Birth in 505 Children Born at Kalaupapa, 1880-1949.

removed to foster homes (usually with relatives) or to the "preventoria" in Honolulu.

The vast majority of these children were out of Kalaupapa by the time they were four years old. Careful efforts were made to isolate the occupants of this nursery from the patients at Kalaupapa. Milk was supplied by cows cared for and milked by non-patients, and other food sources were similarly protected. Parental visits were limited to Sunday, and even then a pane of glass separated parent from child, allowing no direct personal contact. The women who cared for the infants included, from time to time, some non-patient wives living with their husbands (patients). In view of evidence presented below, one wonders about the posssibility of infection from these women, either as passive carriers of infected material or as subclinical cases of leprosy.

After these children were removed from the Kalaupapa nursery, they were placed either with relatives (and presumably exposed to a risk of subsequent transmission at least as high as that in the general population), or they were placed in the closely supervised "preventoria," where their activities and contacts were under careful surveillance. The subsequent attack rates among the children in these two groups were about the same (13.6% in the preventoria and 12.9% with relatives).

During this same period of time the attack rate among Hawaiians and part-Hawaiians in the general public ranged gradually downward from about 2% per decade to under 1%, and then on down to its present level of a small fraction of one per cent. Granting that these Kalaupapa children may represent a more susceptible group than the general public, an attack rate of over six times that seen in the general public strengthens the notion that these children were subject to some sort of occult exposure, presumably while they were at Kalaupapa nursery.

Removal at Birth

Since 1929 the policy has been to remove the infant from the mother at birth, and to remove the infant from Kalaupapa within the first few days of its life. In recent years almost all births have taken place in Honolulu general hospitals, and infants are placed with relatives or in other foster homes in the first month of life. The "preventoria" have been closed.

Approximately 77 children were born under this policy from 1930 to 1949, and *none* of them have subsequently been diagnosed as having leprosy to date (1959), with surveillance of a majority of these children now approaching 20 years.

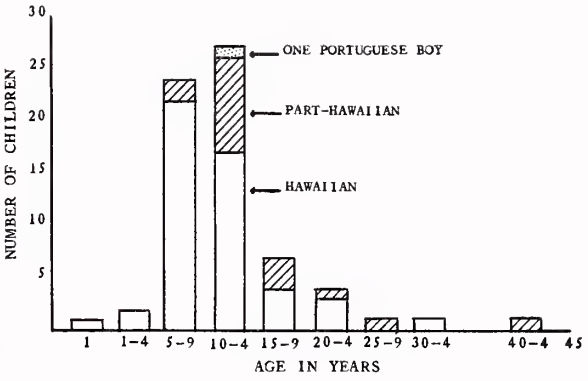


Fig 3. Age at Onset of Leprosy in 69 Children Born at Kalaupapa.

If we apply the 1900-29 rates to this recent group of 77 children, we would expect to have found seven or eight cases by now, instead of none. This certainly argues strongly against prenatal or natal transmission of leprosy, and underlines once again the probability of some form of exposure at Kalaupapa nursery during its three decades of existence.

Figure 3 shows the distribution of the age at onset of the disease by race for the 69 children who developed leprosy. The sharp peak between the ages of 5 and 14 undoubtedly demonstrates the long latent period between exposure and the development of clinically recognizable disease. The two cases with onset after age 30 may well represent transmission taking place after removal from Kalaupapa.

Lara's[1] series of children at Culion, living under conditions of continuous exposure, shows the majority of the 46 affected children developing their earliest "unequivocal leprous lesions" within the first three years of life. This is at a much earlier age than in the Kalaupapa series reported here. The difference may be genuine, or it may be a reflection of more careful and frequent surveillance at Culion, where the children were examined every two or three months, according to Lara. The follow-up of the Kalaupapa children has often been much more sporadic, so that early (and often transient) lesions might have been overlooked, and the recognition of the disease delayed for several years.

Of the 642 children born at Kalaupapa, about half were boys and half were girls; yet of the 69

[1] Lara, C. B., Palafox, C. A., Ignacio, J. L., and Nolasco, J. O.: Children of leprosy patients isolated at birth, given lepromin and BCG injections, then returned to the colony, first report, Internat. J. Leprosy 24:382 (Oct.-Dec.) 1956.

who developed leprosy, 49 were boys and 20 were girls. This marked sex difference is a miniature reflection of the world-wide observation that among leprosy patients you find two or more times as many men as women. This difference presumably relates to differences in susceptibility, and leads to endless speculation about the role of genetic or hormonal influences.

The population of our leprosy hospitals in Hawaii is now quite small (under 300, and shrinking), and there are now relatively few births; so new data along the lines of the above study will not be forthcoming. Individual and careful analysis of selected case records on file may well throw some additional light on the mode of transmission of the disease and the question of the existence and epidemiologic significance of subclinical cases.

Summary and Conclusions

An analysis of studies begun by the late Dr. W. Lloyd Aycock on the disease history of 642 children born at Kalaupapa and living under various conditions of early exposure to leprosy lends support to the following conclusions: 1) maximal exposure to leprosy during infancy (living continuously with infected parents) in a susceptible population leads to subsequent disease in about 40% of the children, with the onset of recognizable disease occurring between 5 and 14 years of age for the majority, and with the rate of attack for boys over two times as high as that for girls; 2) some significant degree of exposure to leprosy may be presumed to have taken place in the Kalaupapa nursery where infants were kept during the first few years of their life during the period from 1903 to 1929, in spite of efforts made to carry out isolation precautions there, and 3) there is very strong evidence that transmission of the disease to the infant does not take place during the prenatal or perinatal period.

Summario in Interlingua

Exposition maximal a lepra durante le infantia resultava in infection clinic con lepra in circa 40 pro cento del infantes de parentes leprose. Le morbo deveniva manifeste inter 5 e 14 annos de etate in le majoritate del casos. Le numero de pueros inficite esseva duo vices illo del pueras. Il pare que le transmission de lepra non occurre durante le periodo pre- o perinatal, de maniera que le remotion del infantes ab inficite parentes al nascentia protege les contra le infection ab iste foco, ben que forsan non ab alteres.

2112 Roosevelt

A visiting pediatrician presents an orderly summary of emergencies important in pediatric practice

Pediatric Emergencies: I

Emergencies of the Child

ARILD E. HANSEN,* M.D., Ph.D., Galveston, Texas

ONE MAY define "emergency" as "a sudden or unexpected happening demanding prompt attention." Insofar as pediatrics is concerned many of the so-called emergencies are not "unexpected" happenings although they may be "sudden" and certainly demand "prompt attention." According to Ferguson[1] the College of General Practitioners gives as the criterion of emergency: "If you are asked to leave what you are doing in order to visit that patient, that is an emergency for this purpose." In one year he had 202 calls, for an average of 17 per month, and drove 242 miles per month. He made no attempt to determine the number which were real emergencies. It is self-evident that what may be an emergency to the mother is not necessarily an emergency to the physician. In order to ascertain some idea of the composition of emergency situations, we examined the records of admissions to the Emergency Room of our institution from April 1 through August 31, 1958. There were 969 emergency room visits by children and as indicated in the accompanying graph of the age distribution (see Figure 1), the younger the child the greater the chance of an emergency visit. It is not surprising, perhaps, that acute respiratory infections during the first two years of life constituted the most common single reason for the emergency visit. Attention is being given to classifying the other causes.



DR. HANSEN

Another approach to the problem of pediatric emergencies is by consideration of the causes of death from study of vital statistics. A century or two ago about one-half of the deaths which occurred were in children under five years. In spite of the great improvement in infant mortality during the 20th century we find that the younger the child the greater the likelihood of death. Vital statistics data for Montana, Minnesota, Texas, and Hawaii reveal that the mortality rates are higher in the younger children. In Table 1 are shown the total number of deaths in these areas for the year 1956. The latest data available for Hawaii were for 1954. In Table 2 are listed the deaths as per cent of total deaths for the age

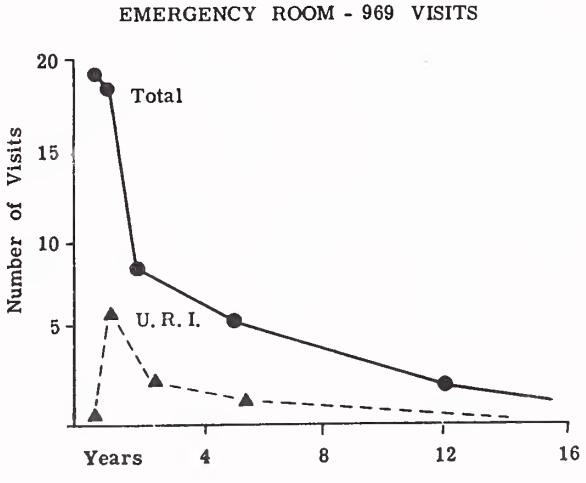


FIG. 1.—Emergency room visits by children of various ages during a 5-month period in the spring and summer.

* Formerly Chairman, Department of Pediatrics, University of Texas School of Medicine. Director of Research, Bruce Lyon Memorial Research Laboratory of the Children's Hospital of the East Bay, Oakland, California.

Presented at the Staff Meeting of the Kauikeolani Children's Hospital, Honolulu, November 5, 1958.

[1] Fergusson, R. S. C.: Some observations on emergency calls in a highland practice, Practitioner 179:306 (Sept.) 1957.

TABLE 1.—*Number of Deaths by Age Groups in Children for the Year 1956.*

	UNDER 1 YR.	1-4 YRS.	5-14 YRS.
United States	108,183	16,603	14,899
Montana	494	87	83
Minnesota	1,776	297	262
Texas	7,262	1,138	909
Hawaiian Islands*	363	61	42

* 1954

TABLE 2.—*Per Cent of the Total Deaths in Children by Age Groups, 1956.*

	UNDER 1 YR.	1-14 YRS.	AV./YR.
United States	7.0	2.0	0.14
Montana	7.6	2.8	0.20
Minnesota	6.0	1.9	0.13
Texas	10.4	2.9	0.21
Hawaii*	15.4	3.4	0.25

* 1954

groups under one year and from one to 14 years for these same areas.

Variations exist not only from state to state, but also from hospital to hospital, city to city, and country to country. However, consideration of deaths alone does not answer the question as to how to approach the subject of "pediatric emergencies" because not all die: many linger on to live a life perhaps even worse than death—crippled; handicapped; or out of contact with reality, i.e., no problem to themselves, but the focal point of great anxiety in the parents and emotional conflicts in the family circle.

In this discussion of the subject of pediatric emergencies we have drawn heavily on such sources as *Handbook of Poisons* by Dreisbach,[2] *Handbook of Pediatric Medical Emergencies* by DeSanctis and Varga,[3] and to the *Symposium on Accidents and Emergencies* by Alway *et al.*[4] We will discuss our subject under the following headings: Respiratory, Cardiac, Nervous, Vascular, Gastrointestinal, Genitourinary, Metabolic, Accidents, Poisoning, Bites, Psychic, Iatrogenic, and Newborn.

Respiratory System

The chief symptoms and signs are dyspnea, retraction, and stridor and may be due to infection, allergy, congenital anomalies, foreign bodies, atelectasis, emphysema, pneumothorax, tumor, or edema.

Infection: Croup is the most common cause of alarm. After ruling out diphtheria, bronchitis, pneumonitis, and pneumonia, we are left the important condition known as laryngotracheobronchitis, which is particularly significant in small infants having sudden respiratory difficulty. Children with laryngotracheobronchitis should be kept under very strict vigilance, preferably in the hospital. If there is evidence of asphyxia, increasing respiratory difficulty, or irregularity in pulse, tracheotomy is necessary and it is best to do this too early rather than too late. A croup tent should be used employing cold vapor and oxygen.

Cultures should be taken as early as possible from both the throat and blood. The combination of sulfonamide, penicillin, and a broad spectrum antibiotic should be used until the specific predominating organism is identified and determinations for antibiotic sensitivity have been made.

The heart should be checked periodically for signs of early failure. Fluids and electrolytes must be given to maintain proper hydration. Sedatives should not be used; however, a teaspoon of whiskey in one ounce of sugar water may be used for this purpose. It is imperative to avoid opiates and atropine.

Foreign Bodies: With the history of choking, gagging, or wheezing in a young child one must always suspect a foreign body. In addition to careful physical examination, x-rays must be taken and often endoscopic study is necessary.

Atelectasis, Emphysema, Pneumothorax: When there is a sudden dyspnea, cyanosis, and tachycardia, these conditions may be causative.

Acute Pulmonary Edema: All too frequently this condition develops and should be brought to mind when there is cough, blood-tinged frothy sputum, cyanosis, dyspnea, rapid pulse, and moist rales. X-ray findings can be very helpful. Oxygen administration is mandatory as well as sedation, employing opiates if necessary. The therapeutic program should be directed towards seeking the basic cause which may be cardiac, renal, toxic (barbiturate), inhalation, overhydration, or polioencephalitis.

Asthma: Respiratory distress due to asthma frequently causes emergency situations. Epinephrine 1:1000 aqueous solution, 0.2-0.3 ml every 20-30 minutes subcutaneously, is not only the therapeutic agent of choice, but also is helpful diagnostically. Aminophyllin, 4 mg/lb. rectally, may be useful in selected cases; also, ephedrine, 15-50 mg by mouth. Steroids are necessary only rarely. Supportive therapy should include bed rest, maintenance of hydration, antibiotics as indicated, and iodides. Special attention should be given to consideration of the emotional phase of the problem.

Cardiac System

Emergencies occur more frequently in this category than one might suppose. Particularly important is the finding of liver enlargement, and in the presence of such signs and symptoms as tachycardia, dyspnea, fine rales, puffiness of face, ashen grey color, cyanosis, twitching, and "anoxia" spells, the diagnosis of heart failure seems inevitable. Acute heart failure may be due to congenital heart disease; acquired heart disease (rheumatic, interstitial myocarditis, and various viral infections); acute infections such as pneumonia; renal disease (glomerulonephritis); the idiopathic cardiomegalies (endocardial fibro-

[2] Dreisbach, R. H.: Handbook of Poisons, Lange Medical Publications, Los Altos, California, 1955.
[3] de Sanctis, A. G., and Varga, C.: Handbook of Pediatric Medical Emergencies, 2nd Edition, The C. V. Mosby Co., St. Louis, Mo., 1956.
[4] Alway, R. H.: Symposium on accidents and emergencies, Ped. Clin. North America, W. B. Saunders Co., Philadelphia, Pa., pp. 759-918 (Nov.) 1954.

elastosis, or glycogen storage disease of the heart); pericarditis with effusion; or the arrythmias such as paroxysmal auricular tachycardia, heart block, auricular fibrillation, ventricular tachycardia, and acute circulatory arrest.

The emergency treatment of cardiac failure must be kept in mind at all times. Although many methods of digitalization are possible, it is well to become thoroughly familiar with one. Digitoxin is recommended by many for rapid digitalization. The following points should be kept in mind.

Digitalis Administration

Digitoxin

Initial dose P.O. or I.M.

< 2 yrs. 0.02 to 0.03 mg/lb.

> 2 yrs. 0.01 to 0.02 mg/lb.

Maintenance dose: 1/10 initial dose/day.

Lanatoside C

Initial dose I.M. or I.V.

< 2 yrs. 0.02 to 0.03 mg/lb.

> 2 yrs. 0.01 to 0.02 mg/lb.

Maintenance dose: ⅓-½ initial dose.

Supportive therapy: Complete bed rest, oxygen, sedation with barbiturates (often it is necessary to use morphine, the safe dosage being 0.1 mg/lb.), diuretics, and steroids may be used. It is imperative to maintain good nutrition and to offer an optimistic attitude for proper emotional conditioning.

Nervous System

Here we may include convulsions, trauma (especially to the head), coma, meningitis, encephalitis, and subdural hematoma.

Convulsions: Perhaps nothing constitutes more of an emergency to parents than when they see their child suddenly overtaken with a seizure. Nothing is more apt to give one the impression of imminent death. We may well realize that children do not die from a convulsion, but it is not easy to assure the parents that this is the case.

Immediate drug therapy—

Phenobarbital—3 mg/lb. I.M., P.O. or rectally.

Paraldehyde, chloral hydrate, or other sedatives.

$MgSO_4$ IM (calcium in 10% solution must be available to counteract possible adverse effects of magnesium).

Ether—open drop administration.

Supportive measures include mouth gag, maintain airway, restrain to prevent injury, oxygen and for high fever, sponge baths, cold enema.

Diagnosis—careful history, lumbar tap, blood culture, BUN, blood sugar, and serum calcium. One must bear in mind the occurrence of other disorders such as tetanus and poisoning.

Head Injury: It is important to follow carefully the eye signs, reflexes, blood pressure, and circulatory status.

Coma: The diagnostic possibilities which should be borne in mind in the presence of coma are: head injury, meningitis, encephalitis, uremia, diabetes, hypoglycemia, acute infection, poisoning, intracranial hemorrhage, and brain tumor or abscess.

Meningitis should be suspected at all times. Spinal taps and cultures both from the spinal fluid and blood should be obtained *before* therapy is instituted. Waterhouse-Fridericksen syndrome may develop. If this occurs, one must check blood pressure every 30 minutes, and if indicated, administer hydrocortisone 100 mg IV, then 50 mg q 6 h. It is necessary to maintain fluids and a good nutritional state, and to follow the serum electrolytes. Antibiotics employed should include those suitable according to the results of bacterial cultures.

Subdural Hematoma: One must have a high index of suspicion for this condition in prematures, multiple births, difficult deliveries, postnatal trauma, convulsions, vomiting (especially projectile), infection, failure to gain, irritability, stupor, retinal hemorrhage, or increasing head size. Significant is the bulging fontanelle which is not relieved by spinal tap; also, the failure to respond clinically within 48 to 72 hours.

Diagnosis—subdural taps bilaterally. Results are negative if there are but a few drops of clear, colorless fluid; abnormal if yellow or bloody and not clotting on standing, also increased pressure or elevation of protein content. Spinal tap should be performed to rule out coexisting subarachnoid hemorrhage. Treatment requires repeated subdural taps—removing 10-12 ml daily until negative taps are obtained. Neurosurgical intervention may be necessary, hence, one must have the consultation of a neurosurgeon.

Vascular

Embolism, thrombosis, and hemorrhage may be responsible for an acute emergency situation in children.

Gastrointestinal

The acute surgical abdomen, sudden hemorrhage, and acute infections frequently cause emergency situations to develop in children.

Genito-urinary

Anuria and oliguria-uremia may be due to dehydration, cardiac disease, renal disorder, shock, toxic substance or sulfonamides. Treatment—employ fluids to equal the 24-hour output plus the insensible water loss (100-300 ml). Hemodialysis by use of the artificial kidney may be necessary. Periodic laboratory studies should include BUN, serum Na, K, Cl, and CO_2, plasma proteins, and hematocrit.

Hematuria may produce an emergency situation. This is especially important in cases of injury.

Mass in abdomen: A tumor mass in the abdomen should be considered malignant until proved otherwise.

Urinary Retention: One must look for the cause. For treatment one should try warm baths, moist warm compresses, enemas, and finally catheterization.

Infections: A great variety is possible. Bacteriological studies should be made *before* therapy is instituted.

Metabolic

Galactosemia: Early jaundice, cataracts, evidences of central nervous system degeneration, and the presence of reducing substance in urine when using Benedict's solution are the clinical features of this inability to metabolize galactose. If the urine is negative for glucose but is positive for reducing substance by Benedict's solution, this should make one suspicious of the presence of galactosuria. The "total blood sugar" may be high, yet

the true glucose value is low. Specific tests for galactose should be made. The use of a milk diet gives phenomenal results if started early.

Oligophrenic phenylpyruvia: In the presence of slow development or if the child is retarded, it is well to test the urine with ferric chloride which gives a blue color when the urine is acidified. A phenylalanine free diet is helpful.

Myasthenia gravis: Sudden marked weakness which responds readily to prostigmine (0.05-0.5 mg) is valuable not only for diagnosis, but also for treatment.

Diabetic Coma: For emergency treatment a procedure such as the following is found to be extremely useful.

Fluids—100 ml/Kg
60 ml/Kg Na lactate M/6, ½ IV, ½ Sbc.
40 ml/Kg Ringer's (hypotonic) solution, IV or Sbc.
Insulin—2 u/Kg, ½ IV and ½ Sbc, then ½ u/Kg q 6 h.
Potassium salt administration—1-2 gm of KCl *after* the patient is voiding.
Milk or orange juice covered by insulin according to the urinary sugar reaction.

Accidents

Were any one physician called upon to discuss the subject of "pediatric emergencies" he might well choose to spend most of his time on "accidents." In children, accidents have now become the greatest cause of death, and for each death from accidents, perhaps 100 are crippled or handicapped. The younger the child the greater the likelihood of death by accident. Even in the first year of life the number of deaths from accidents is greater than any other year other than for the early twenties. In 1950-51 in children between the ages of one and 19, accidents accounted for 37 per cent of the deaths, compared to 9 per cent due to malignancy, 7 per cent pulmonary infections, and 5 per cent to congenital disorders. For nonmotor deaths as indicated in Figure 2, the younger the child the greater the chance of death by accident. About 40 per cent occur in the homes; in some series this is even higher. Of home accidents the following distribution has been found: kitchen 34 per cent, bedroom 27 per cent, bathroom 15 per cent, living room 9 per cent, yard 5 per cent, foyer 2 per cent, cellar 1 per cent, other 7 per cent. The most common occurrence is in the two to five year age group. The causes may be burns, conflagration, drownings, falls, and poisonings. It is our special responsibility to lead a war of prevention. Accidents must be anticipated and many can be prevented.

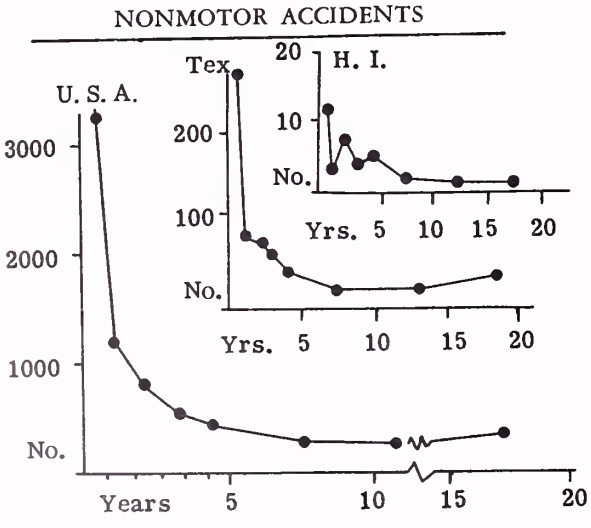


FIG. 2.—Deaths in children from nonmotor accidents.

Poisoning

At all times poisoning must be thought of as a cause of acute symptoms in children. Over 10 per cent of accidental deaths are due to poisoning. Aspirin and barbiturates are the leaders. It is stated that the rate of poisoning in the United States is four times the rate of poisoning in England. In the report of 8,000 cases from 23 Poison Control Centers the following is noted: medications (internal) 48 per cent, medications (external) 5 per cent, household preparations 11 per cent, petroleum distillates 8 per cent, cosmetics 1 per cent, pesticides 13 per cent, miscellaneous 14 per cent. The common substances causing poisoning are: lye, kerosene, sodium fluoride, barbiturates, salicylates, lead, atropine, camphor and camphorated oil, moth repellents, aniline dyes, ferrous sulfate, mushrooms (inedible), phosphorus, strychnine, and boric acid. In fact, almost anything the child can get hold of may be poisonous to him. Every time the physician prescribes a medicine he must remember that a child may obtain possession of it. Physicians must be careful in bringing home drug samples—they must be placed out of reach of their own children. In the event of suspected poisoning unless one is absolutely certain, it is best to call a Poison Control Center. General rules include:

1. Remove poison—keep for identification.
2. Antidote.
3. Supportive therapy.
   If inhaled, fresh air, oxygen, artificial respiration.
   If surface, apply large amounts of water, soap, alcohol.

Bites

Insect bites may produce severe reactions and even be lethal. Bee stings may be effectively controlled with epinephrine and sometimes the administration of antihistamines, for example, Benadryl.

Snake bite [elsewhere than in Hawaii—ED.]: It is well to keep the patient quiet—in other words stop all ac-

tivity, place the affected part in dependent position, apply a light tourniquet and make a cross incision over the area, apply suction for 20 minutes of each hour, and use moist sterile saline dressings. Polyvalent antivenom serum at site of wound IM and should be repeated at one-half hour interval for as much as 15 doses. Cortisone and antibiotics may be used, and anti-tetanus prophylaxis.

Dog: Tie up animal. Cleanse wound with detergent. Be aware of tetanus and [outside of Hawaii—ED.] rabies.

Robies: Give hyperimmune anti-rabies serum (Lederle), 10-60 ml within 24 hours of bite. Vaccine—14 injections. Tetanus toxoid and antibiotics.

Behavior and Psychiatric Problems

An important part of the responsibility of physicians whose practice concerns children is to be aware of the emotional and behavioral problems. The physician must be alert continuously to the manifestation of these problems in order to employ measures for early treatment or prevention. Routine well baby care is partly directed towards this end.

According to my colleague Dr. James C. Flanagan, a child psychiatrist, there are three main conditions in which psychiatric emergencies exist in childhood and adolescence. The first of these is suicide or attempted suicide which is relatively rare prior to adolescence, but does occur. Over a hundred children under the age of fifteen commit suicide each year, and the number in the age group of fifteen to nineteen exceeds one thousand annually. Severe depression and suicidal preoccupation do then constitute a psychiatric emergency requiring immediate hospitalization even in the younger age group.

The second major psychiatric emergency is severe anorexia nervosa, found exclusively in preadolescent and adolescent girls. These children are frequently not seen until late in the course of the illness and may present with severe electrolyte imbalance, acute or chronic dehydration, vomiting, diarrhea, and occasionally massive gastrointestinal hemorrhage.

The third major psychiatric disturbance requiring immediate attention is the child with severe acting-out and aggression toward himself, others, or the community. It is often necessary that these children be detained in a psychiatric hospital or ward, for the protection of others as well as themselves.

Iatrogenic

In the whole field of pediatric emergencies we as physicians may contribute to or actually create the emergency situations.

Antibiotic and sulfonomides: All too many serious situations arise because chemotherapeutic or antibiotic agents are given *before* it has been shown that there is a need for them.

Transfusions: One should check and double check for compatible blood groups. Virus hepatitis may develop as well as erythroblastosis with subsequent kernicterus.

Oxygen: It is now well known that retrolental fibroplasia may result from exposing the premature infant to too high a concentration of oxygen for too long.

Allergy: Anaphylactoid reactions can be serious. Symptoms and signs which suggest anaphylactoid shock are: skin—flush, burn, itch, urticaria; respiratory—cough, wheeze, dyspnea, pain; cardiac—pallor, syncope, coma, hypotension, tachycardia. Treatment should be directed to include the following: tourniquet; epinephrine IM or IV 1:1000 solution, 0.2-0.5 ml, repeat every 5-10 minutes; antihistaminics; Benadryl, 20 mg IV; Chlortrimeton, 10 mg.

Steroids: The physician must be aware of difficulties which may arise from their use; hence, they should not be used indiscriminately.

Woter ond Electrolytes: These require careful consideration in every instance. The following points may be outlined:

Overhydration—usually from excess H_2O or salt parenterally.

Dehydration—abnormal losses, metabolic effects (fever, hyperventilation), failure to maintain required amounts.

Hypertonic—diarrhea, thirst, steroid administration.

Hypotonic—diarrhea, low sodium intake, diuretics, sweat, body fluids removed, adrenal insufficiency.

Hypokolemia—insufficient intake of potassium, vomiting, gastroduodenal suctioning, steroid administration. Signs and symptoms include weakness, hypotonia, abdominal distention, flaccid paralysis, cyanosis, muscle twitchings, paralysis of respiratory muscles, irregular pulse.

EKG shows S-T depression, T-waves low and inverted, Q-T prolonged, U prominent.

Hyperkalemia—excess intake of potassium, anuria, dehydration, adrenal insufficiency. Signs and symptoms include: weakness, ashen color, slow irregular pulse, low blood pressure and cardiac arrest.

EKG shows T-waves elevated, S-T depressed, Q-R-S widened, P-R prolonged, QRS-T biphasic, P disappears.

Immunologic and nutritional: Failure to carry out the necessary program for immunizing each child as well as dietary supervision may be responsible for the development of an emergency situation. Malnutrition may develop. Hypervitaminosis A or D may occur.

Drugs: Poisonings, even fatalities, can result especially from aspirin, ferrous sulfate, antihistaminics, barbiturates, mercury, lead, steroids, boric acid.

Emotional: The physician should do his best to prevent the development of fear situations in children by education of the parents for proper conditioning of the child for medical and surgical treatment either in the home or the hospital.

Irrodiotion hozords: Inasmuch as leukemia may be in part due to irradiation exposure, the physician should be aware of this danger.

Eczemo vaccinotum: Never should a child be vaccinated if he has an eczematous eruption or any member of the family has eczema.

The problem of emergencies of the newborn period will be discussed in a following article of this JOURNAL.

Don't overlook actinomycosis as a possible cause of empyema.
Drainage and plenty of penicillin are the keynotes in its treatment.

Actinomycotic Empyema

A Case Report

JOSEPH A. HAWKINS, Major, MC, AND
JOSEPH L. MARCARELLI, Captain, MC, Honolulu

PULMONARY ACTINOMYCOSIS is not an extremely common disease. Certain factors, however, make its recognition important. These include the ability to mimic other chest diseases, chronicity with prolonged morbidity, high mortality if undiagnosed and untreated, and finally, responsiveness to specific therapy. Several excellent reviews of the historic, epidemiologic and pathogenetic aspects of this disease are available.[1]



DR. HAWKINS

The following case resembled at first a tuberculous pleural effusion and then a purulent empyema. The response to treatment has been dramatic.

Case Summary

This 32-year-old Hawaiian coffee farmer was born in Kona, Hawaii, and lived there his entire life with the exception of about a year in 1948-1949 when he lived on the Island of Oahu, Hawaii, and during World War II when he had tours of duty in Texas and the Philippine Islands. He enjoyed excellent health all of his life and was well until approximately two months prior to admission when he suddenly developed fever, chills, and sweats. He thought he was suffering from influenza. He was seen by his local physician and given an injection of penicillin. This apparently did no good; three days later he became aware of severe, right-sided pleuritic chest pain which was markedly aggravated by breathing.

Approximately 16 days following his first visit he was seen again by his local physician and an x-ray of the chest was done. Pleural effusion was found on the right side and thoracentesis was performed with removal of approximately 250 cc of amber colored fluid. Smears and cultures of this fluid for acid-fast bacilli were negative. PPD#1 was done at that time and was also reported as negative.

He continued to have fever, night sweats, chest pain, malaise, and weight loss. Three more thoracenteses were done during this period, all of which were nonproductive. He lost approximately 30 pounds in weight and during the two to three weeks prior to admission he developed a cough which was productive of thick, whitish sputum. He had dyspnea on exertion but no orthopnea.

On 3 January 1959 he was admitted to Tripler U. S. Army Hospital for evaluation and treatment.

On admission temperature was 100.6°F., pulse 104, respiration 18, blood pressure 124/78, height 6 feet, weight 200 pounds. Patient was a well developed, well nourished Hawaiian man, in no acute distress. There were slight respiratory lag of the right chest on inspiration and dullness to percussion in the right base posteriorly and the right lateral aspect of the chest. Breath sounds were not heard in this area, and fremitus was absent.

On admission hematocrit was 41, hemoglobin 11.5, white blood count 13,300, PMN 76%, lymphocytes 21%, monocytes 3%. Cardiolipin was negative. Urinalysis: specific gravity 1.020 with a slight trace of albumin and 2-3 WBC's per high power field. PPD#1 and #2, and histoplasmin skin tests were negative.

Three sputum cultures revealed Alpha hemolytic streptococci and Neisseria catarrhalis. Six sputum smears and cultures for acid-fast bacilli were negative. Culture of empyema material removed at thoracentesis and at open thoracotomy grew out Actinomyces bovis.

Admission chest film revealed moderate (Fig. 1) right pleural fluid and an air fluid level was demonstrated in the third anterior interspace. Impression was empyema with an air fluid pleural pocket.

Serial chest films subsequent to thoracotomy showed progressive improvement in the appearance of the chest

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[1] Peabody, J. W., and Seabury, J. H.: Actinomycosis and nocardiosis, J. Chron. Dis. 5:374, 1957. Cope.[2] Harvey *et al.*[3]

[2] Cope, Z. A.: Actinomycosis, 1938 Oxford University Press, London.

[3] Harvey, J. C., Cantrell, J. R., and Fisher, A. M.: Actinomycosis: its recognition and treatment, Ann. Int. Med. 46:868, 1957.



FIG. 1

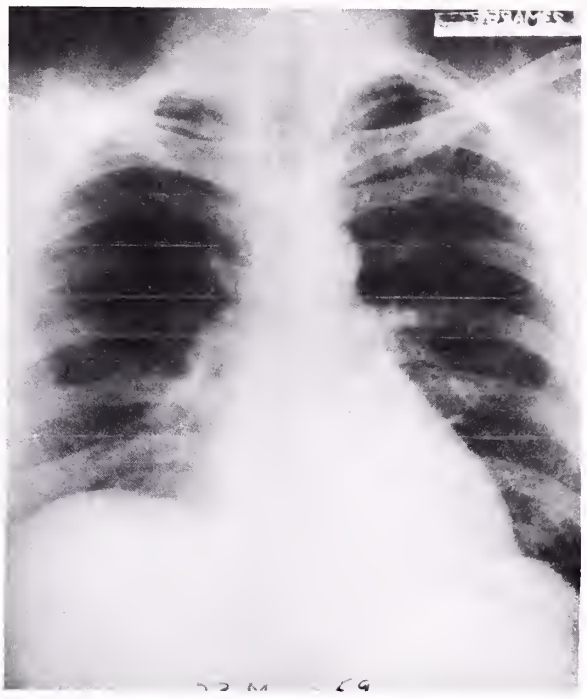


FIG. 2

with ultimate disappearance of the empyema. By 2 March 1959 all that remained was some pleural thickening along the right chest wall. Chest film (Fig. 2) was taken shortly before discharge. Repeat blood counts and urinalyses were normal.

On the second hospital day a thoracentesis was performed with removal of about 80 cc of thick, greenish-yellow, very foul-smelling pus. This was submitted for culture. Patient was started on penicillin, streptomycin, and chloromycetin. On the sixth hospital day, open thoracotomy drainage was performed with removal of approximately 350 cc of similar-appearing material. This was also submitted for culture.

Both grew out Actinomyces bovis, therefore the chloromycetin, and streptomycin, were discontinued and penicillin was increased to 2.4 million units daily. He was also started on sulfadiazine 2 grams daily and saturated solution of potassium iodide. Patient was maintained on sulfadiazine and penicillin for a total period of approximately three months.

Subsequent to the open thoracotomy and institution of penicillin and sulfadiazine therapy the patient became afebrile and at this time he began to feel quite well. His appetite improved appreciably, he progressively gained weight and within about two months he had regained all of his lost weight. Likewise his chest films showed progressive improvement and within approximately two months from the time of admission his chest was essentially normal except for some residual pleural thickening. After a total course of approximately three months of penicillin and sulfadiazine therapy the patient was discharged and appeared subjectively and objectively cured.

Discussion

Thoracic actinomycosis accounts for only about 15 per cent of the cases of infection with Actinomyces bovis.[1] The classic cases consist of lower lobe lesions with extension to the pleura, involvement of the thoracic wall, and production of draining sinuses. In recent years cases are being encountered and diagnosed before this entire chain of events takes place and thus the similarity to other chronic pulmonary disease is becoming more common.

Jepson *et al.*[4] reported a case first seen seven years prior to definitive diagnosis which was clinically indistinguishable from tuberculous pleural effusion. Warthin and Bushueff[5] reported three cases, all of which presented with abnormal chest x-rays showing a fan-shaped density extending from the hilum into a lower lobe superior segment strongly suggesting carcinoma. None of the three showed any chest wall or pleural involvement and two underwent thoracotomy because of the suspicion of malignancy. Peabody and Seabury[1] clearly point out the clinical similarity of thoracic actinomycosis and nocardiosis. The complication of superior vena caval obstruction is illustrated by the case reported by Martin, *et al.*[6]

Actinomyces bovis is a gram-positive, nonacid-fast, anaerobic organism. Culture of the organism from exudate in draining sinuses, from material obtained by thoracentesis and from exudate or washings obtained bronchoscopically, as well as identification of the organism in surgical specimens, is sufficient evidence to establish its etiologic

[4] Jepson, E. M., Rose, C. F., and Tonkin, R. D.: Thoracic actinomycosis, Brit. Med. Jour. 1:1025, 1958.
[5] Warthin, Thomas A., and Bushueff, Boris: Pulmonary actinomycosis, AMA Arch. Int. Med. 101:239, 1958.
[6] Martin, W. J., Nichols, D. R., Wellman, W. E., and Weed, L. A.: Disseminated actinomycosis treated with tetracycline, AMA Arch. Int. Med. 97:252, 1956.

role in a suspected case. The finding of "sulfur granules" in either drainage or tissue specimens, while highly suggestive, is not diagnostic, since Nocardia and other organisms may produce similar granules.[7] Since Actinomyces bovis can and frequently does exist in the mouth without causing any disease, ordinary sputum cultures are not diagnostic unless supported by a consistent clinical picture and characteristic response to therapy.

The keystone of present-day treatment of pulmonary actinomycosis is prolonged administration of large doses of penicillin,[1] 2-4 million units daily for at least two to three months and in many cases longer. Sulfadiazine helps and should also be given. Broad spectrum antibiotics have been shown to be efficacious,[9] but certainly not superior. Potassium iodide, although it is time-honored and was given in this case, is probably of little help.[3] Isoniazid has been reported to be of value.[11] In this regard it is worthwhile to note a patient reported by Wingo and Williams[12] who developed pulmonary actinomycosis while on anti-tuberculous chemotherapy including 300 mgm of isoniazid daily. Resectional surgical procedures are seldom necessary; however, as in our case, the establishment of drainage by surgical means is an important feature in treatment of patients with actinomycotic empyema. With proper treatment, excellent results can be expected.

[7] Auger, C.: Human actino-bacillary and staphylococcic actinophytosis, Am. J. Clin. Path. 18:645, 1948. Moore.[8]

[8] Moore, M.: Radiate formation on pathogenic fungi in human tissue, AMA Arch. Path. 42:113, 1946.

[9] McVay, L. V., Jr., and Sprunt, D. H.: A long-term evaluation of Aureomycin in the treatment of actinomycosis, Ann. Int. Med. 38:955, 1953. Martin *et al.*[6] Littman *et al.*[10]

[10] Littman, M. L., Paul, J. S., and Fusillo, M. H.: Treatment of pulmonary actinomycosis with chloramphenicol: report of a case, J.A.M.A. 148:608, 1952.

[11] McVay, L. V., Jr., and Sprunt, D. H.: Treatment of actinomycosis with isoniazid, J.A.M.A. 153:95, 1953.

[12] Wingo, C. F., and Williams, R. D.: Pulmonary actinomycosis diagnosed by lung biopsy, Am. Rev. Tuberc. 76:660, 1957.

Summary

A case of thoracic actinomycosis in a Hawaiian coffee farmer has responded to large doses of penicillin and sulfadiazine.

Summario in Interlingua

Actinomycosis pulmonar con empyema pote similar pleuritis tubercular o empyema purulente. Illo pote esser diagnosticate solmente per le culturation de Actinomyces bovis ab le exsudato. Le tractomento require 2 a 4 milliones unitates de penicillina per die durante duo a tres menses o plus, e etiam sulfadiazina. Ioduro de kalium es de pauc valor, e le efficacia de isoniazido es questionabile. Antibioticos a large spectros es probabilemente efficace sed non superior a penicillina. Es reportate un caso con bon successo post tres menses de tractamento. Le patiente esseva un cultivator de caffe in Hawai qui non habeva essite foras del stato depost le secunde guerra mundial.

Tripler U. S. Army Hospital.

The Physician and Rehabilitation

TORU NISHIGAYA, M.D.,* Honolulu

THE PRACTICE of rehabilitation for any physician begins with the belief and basic philosophy that his responsibility does not end when the acute illness is ended or surgery completed. It ends only when the patient is re-trained to live and work with what he has left. This basic concept of the physician's responsibility can be achieved only if rehabilitation is considered an integral part of medical services.

The physician has always practiced some aspects of rehabilitation therapy, though he may not have thought of it as such.

Traditionally, the saving of human life and the relief of suffering have been his primary goals. Those individuals disabled by congenital defects, disease, injury, or infirmities of age were accepted as having suffered the expected consequences of their difficulties and were regarded as hopeless.

Today, because life is preserved it does not necessarily mean that a good cure has been obtained. The diagnosis and treatment are often so absorbing that there is increasing danger of focusing too much attention on the disease without regard for the person as a whole. The true significance of rehabilitation and its real distinction from preventive and curative treatment rest upon the conviction that both lay and medical resources can be utilized to prevent and treat those disabling complications.

Rehabilitation is every physician's business. Experience has shown that much of all rehabilitative processes can and should be done by the practioner responsible for the patient's primary medical care. To meet the needs of the more difficult cases, the physician can refer patients to Rehabilitation Centers where a "team" approach can be utilized—using the special skills of specially trained physicians, physical and occupational therapists, social workers, speech and hearing therapists, nurses, vocational counselors, psychologists, and prosthetics specialists.

These co-professional personnel act as members of evaluating and therapeutic teams. However, one person must be responsible—as the patient cannot effectively be treated by committees. This is the physician's responsibility. Medical guidance is necessary for rehabilitation to have purpose, for regardless of the type of disability, the responsibility of the physician to his patient cannot end when the acute illness or injury has been cared for. In addition, because of the high prevalence of chronic illnesses and their tendency to be prolonged, the basic elements of early detection and adequate medical care must be complemented by rehabilitation. These services should continue as long as the patient can profit from them.

We must not lose, by neglect of the social and emotional life of the patient, those controls which are not affected by the illness. Custodial institutional care contributes to a deterioration of the patient far beyond what is inherent in the development of the disease itself. It is, therefore, essential that physically degenerative and socially degenerative processes that diminish the individual's capacity for self-maintenance be prevented, and that we direct efforts at the restoration of the capacity of the individual to maintain himself. We must protect the health of the patient even though we cannot cure that part of him which is specifically diseased.

The patient must maintain some goal for his activity. This may mean a return to the status of self-help. It may mean employability, the traditional goal of rehabilitation efforts. Productivity has more than an economic connotation. In any case activity has an important social meaning in terms of the status of the individual.

We must emphasize that we are not dealing solely with physical disability; we are concerned with a person. We must consider and evaluate the patient's physical capacities and consider his vocational, psychological, and social status, since these are important factors in his eventual social integration.

In any case, the medical care is not complete until the patient has been trained "to live and to work with what he has left."

It is hoped that this Governor's Institute on Rehabilitation will serve as a catalyst in promoting the concept of rehabilitation and its basic techniques.

* President, Hawaii Medical Association.

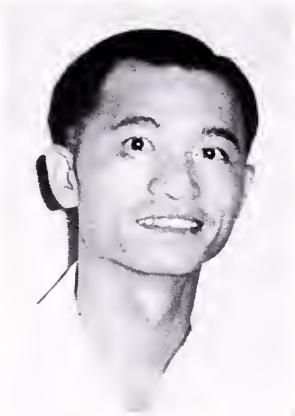
An address delivered at the opening of the Governor's Rehabilitation Institute, January 11, 1960, in Honolulu.

The cesarean section rate at St. Francis Hospital, though it has doubled since World War II, is still 2.37 per cent lower than the U.S. mainland average.

Cesarean Sections at St. Francis Hospital, 1949-1958

CHEN-TUNG CHANG, M.D.,*
Tai Chung Hsein, Formosa, Free China

A STUDY OF cesarean sections performed at St. Francis Hospital, Honolulu, Hawaii, during the ten-year period, 1949 through 1958, revealed a rate of 2.37 per cent; this is shown in Table 1. No increase in rate is noted in recent years at this hospital, whereas several authors[1] reported an increased rate in recent years. The incidence of cesarean sections at New York Lying-in Hospital[2] is reported as 6 per cent and a recent study from San Francisco[3] revealed a rate of 10 per cent. In the City Hospital of Cleveland it is 2.4 per cent and in St. Louis Maternity Hospital, 2.7 per cent.



DR. CHANG

The increased incidence of cesarean sections may be attributed to abdominal sections' having become relatively safe because of improvements in anesthesias and operative techniques, and the use of antibiotics. All literature reviewed proved without question that pregnancy and parturition are safer today than 20 years ago in vaginal deliveries as well as in cesarean sections. The review also revealed that there has been an increase in the repeat cesarean section category.

The cesarean section rate for the ten-year period preceding this study, (1939-48) was 1.99 per cent (see Table 2).

Table 3 shows the various types and incidence of cesarean sections performed by the attending physicians or by the obstetrical residents. There was a preponderance of low cervical sections, as

* Formerly Chief Resident in Obstetrics and Gynecology at St. Francis Hospital.

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Schroll, J. C., and Cakina, L. A.: A twenty-four year review of cesarean section at Kansas University Hospital, J. Kansas M. Soc. 55: 131 (Mar.) 1954.

[2] Smith, E. F., and MacDonald, F. A.: A cesarean section evaluation of current practice in New York Lying-in Hospital, Obst. & Gynec. 2:0593 (Dec.) 1953.

[3] Soule, S. D.: Ten year study of cesarean section in St. Louis Maternity Hospital, Am. J. Obst. & Gynec. 36:648 (Oct.) 1938.

TABLE 1.—*Annual Rate of Cesarean Sections at St. Francis Hospital, 1949-1958.*

YEAR	NO. OF DELIV.	NO. OF C. S.	C. S. PERCENTAGE
1949	1,508	40	3%
1950	1,281	33	3
1951	1,284	27	2
1952	1,454	31	2
1953	1,435	28	2
1954	1,496	38	3
1955	1,335	29	2
1956	1,378	34	2
1957	1,448	40	3
1958	1,628	39	2
Total	14,246	339	2.37%

TABLE 2.—*Annual Rate of Cesarean Sections at St. Francis Hospital, 1939-1948.*

YEAR	NO. OF DELIV.	NO. OF C. S.	C. S. PERCENTAGE
1939	342	3	1%
1940	400	1	0.25
1941	449	3	1
1942	523	6	1
1943	903	9	1
1944	1,367	21	2
1945	1,554	47	3
1946	1,786	31	2
1947	1,656	53	3
1948	1,634	39	2
Total	10,614	213	1.99%

indicated in Table 3. The rate of 85 per cent is much higher than the next most frequent type of section, the classical cesarean section, with a rate of 12 per cent. Extraperitoneal cesarean sections were performed very infrequently.

Cesarean hysterectomies were performed in four cases for the following reasons: two for ruptured uterus, one for placenta accreta which was found at the time of repeat section, and one for uncontrollable bleeding in a comatose patient with leukemia, who expired three hours after surgery. (See the case presentations of maternal mortality cases.)

The list (Table 4) is prepared in the order of frequency. The indications were not always clear-cut because more than one indication was present in several cases. However, for statistical purposes only the most important indication is given for any one case.

There were 118 repeat cesarean sections, and this compared favorably with several series.[4] The

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Hofman, J. W., and Atlas, J.: Cesarean section at Indianapolis General Hospital, Obst. & Gynec. 4:496 (Nov.) 1954.
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TABLE 3.—*Types of Cesarean Sections.*

1. Low cervical cesarean sections	287	85%
2. Classical cesarean sections	41	12
3. Extraperitoneal cesarean sections	7	2
4. Cesarean-hysterectomy	4	1
Total	339	100%

TABLE 4.—*Indications for Cesarean Sections.*

1. Repeat cesarean section			118	35%
2. Cephalopelvic disproportion			71	21
3. Hemorrhage			63	18
a. Abruptio placenta	21	6%		
b. Placenta previa	38	11		
c. Rupture of marginal sinus	4	1		
4. Abnormal presentation and position, obstructed birth canal			40	12
a. Transverse lie	7			
b. Prolapse of cord	6			
c. Primigravida breech	4			
d. Brow presentation	4			
e. Face presentation	4			
f. Previous myomectomy	3			
g. Deformity of pelvis	2			
h. Uterine fibroid	2			
i. Transverse arrest	2			
j. Persistent occiput-posterior	2			
k. Ovarian cyst	2			
l. A. and P. repair	1			
m. Prolapse of arm	1			
5. Toxemia of pregnancy			19	6
a. Pre-eclampsia	15			
b. Eclampsia	4			
6. Uterine inertia	7			
7. Fetal distress	6			
8. Prolonged labor	5			
9. Diabetes mellitus	5			
10. Rupture of uterus	2		28	8
11. Placenta accreta	1			
12. Carcinoma of stomach, 34 weeks	1			
13. Leukemia, 34 weeks	1			
Total			339	100%

TABLE 5.—*Comparative Statistics for Cesarean Sections According to Various Authors.*

	PREVIOUS SECTIONS	C. P. D.	PLACENTA PREVIA	ABRUPTIO PLACENTAE	TOXEMIA
William & Hollenbeck (1946-49)	30%	28%	12%	5%	7%
Rosensohn et al. (1932-42)	18	52	14	6	1
Kinstner (1940-49)	23	51	7	6	3
Cody (1941-50)	32	32	12	3	3
D'Esopo	12	54	8	2	4
Diddle et al.	28	18	6	5	10
Zarou (1944-51)	31	28	14	2	5
Posner et al (1943-51)	27	22	8	6	4
Mean average	26	33	10	4	5
Percentage at St. Francis	35	21	11	6	6

second major indication was cephalopelvic disproportion. There were 71 cases or 21 per cent in this category. The third major indication was hemorrhage, with in incidence of 18 per cent. The fourth most frequent indication was abnormal presentation and position and there were 40 cases or 12 per cent. The fifth most common indication was toxemia of pregnancy, having a rate of 6 per cent.

Table 6 shows that 52 per cent or 61 cases out of 118 cases of repeat sections were due to cephalopelvic disproportion. The second most frequent indication was hemorrhage in which category there were 18 cases or 15 per cent. Toxemia of pregnancy was the third cause for repeat section. There were 15 cases or 13 per cent in this group. Thirteen cases or 11 per cent were due to abnormal presentation and position.

Table 7 indicates that 207 out of the 339 sections, or 61 per cent, were done on patients between the ages of 21 and 30. The next highest incidence was in the 31-40 age group in which there were 81 cases or 22 per cent. Eleven per cent or 34 cases were within the age group of 11-20, and 5 per cent or 17 cases were 41 or older.

A majority of the cases, 91 per cent, were given spinal anesthesia; 23 cases or 7 per cent received cyclopropane; and eight cases were given local anesthesia supplemented with sodium pentothal. One case, a patient in coma with leukemia, received only oxygen.

A majority of the cases, 99 cases or 84 per cent, had only two sections, whereas 18 cases or 15 per cent had three sections, and one per cent or one case had four sections. The low incidence of multiple cesarean sections in this institution is probably due to patients' being sent to other hospitals for later sections with tubal ligation.

A review of the pelvimetry findings showed 29 cases or 41 per cent to have mid-plane contraction, 19 cases or 27 per cent had inlet contraction, 17 cases or 24 per cent did not have x-ray evidence of cephalopelvic disproportion.

The highest incidence of morbidity was due to puerperal infection. This occurred in 5.60 per cent of all sections followed by 3.83 per cent incidence of shock.

Maternal Mortality Rate

There were two maternal deaths, an incidence of 0.58 per cent. One was due to a medical complication; therefore, the corrected mortality rate was 0.26 per cent.

Case B-11394

This 32-year-old gravida 1 para 0 Hawaiian-Chinese woman whose last menstrual period was 10-15-55, with estimated date of confinement 7-22-56, was admitted on

TABLE 6.—*The Primary Indications for Cases Requiring Repeat Cesarean Sections.*

INDICATIONS		CASES	PERCENTAGE
1. Cephalopelvic disproportion		61	52%
2. Hemorrhage		18	15
a. Placenta previa	14		
b. Abruptio placentae	4		
3. Toxemia of pregnancy		15	13
a. Pre-eclampsia	14		
b. Eclampsia	1		
4. Abnormal presentation and position		13	11
a. Primigravida breech	4		
b. Brow presentation	3		
c. Transverse lie	4		
d. Obstructed birth canal	1		
e. Persistent occipitoposterior	1		
5. Prolonged labor	6		
6. Uterine inertia	2		
7. Fetal distress		11	10
8. Diabetes mellitus	1		
Total		118	100%

TABLE 7.—*Age Distribution of Cesarean Section Cases.*

YEAR AGE:	11–20	21–30	31–40	41
1949	1	27	10	2
1950	3	19	11	0
1951	2	14	7	4
1952	1	25	4	1
1953	3	18	6	1
1954	2	25	9	2
1955	4	14	8	3
1956	5	15	13	1
1957	5	25	9	1
1958	8	25	4	2
Total	34	207	81	17
Percentage	11%	61%	22%	5%

TABLE 8.—*Types of Anesthesia Used for Cesarean Sections.*

TYPES OF ANESTHESIA	CASES	PERCENTAGE
Spinal	307	91%
Cyclopropane	23	7
Local pentothal	8	2
Oxygen only	1	0.60
Total	339	100%

TABLE 9.—*Number of Patients Having Two or More Cesarean Sections.*

NO. OF REPEAT SECTIONS	CASES	PERCENTAGE
Second section	99	84%
Third section	18	15
Fourth section	1	1
Total	118	100%

Nationality Classification of C.P.D. Cases: 71 Cases

A. No C.P.D. by x-ray but C.P.D. clinically....17 cases
1. Japanese 4
2. Portuguese....4
3. Filipino 2
4. Hawaiian....2
5. Portuguese-Hawaiian 2
6. English-Irish 1
7. Hawaiian-Chinese....1
8. Spanish-Italian 1

B. Inlet contraction ....19 cases
1. Japanese....4
2. Portuguese....4
3. Filipino....2
4. Chinese....1
5. Korean 1
6. Dutch 1
7. Italian....1
8. Japanese-Hawaiian....1
9. Puerto Rican-Hawaiian 1
10. Chinese-Hawaiian....1
11. Danish 1
12. Portuguese-Spanish-Hawaiian 1

C. Mid-plane contraction ....29 cases
1. Japanese....6
2. Filipino....6
3. Portuguese....3
4. Chinese....3
5. Chinese-Hawaiian....2
6. Portuguese-Hawaiian 2
7. Filipino-Portuguese....1
8. Chinese-Portuguese....1
9. Armenian....1
10. Italian....1
11. Hawaiian-Italian....1
12. German 1
13. Spanish-Irish 1

D. Outlet contraction ....3 cases
1. Portuguese....2
2. Japanese....1

TABLE 11.—*Morbidity.*

1. Puerperal infection	19	5.60%
a. Urinary tract infection	17	
b. Wound infection	2	
2. Shock	13	3.83
3. Unknown	10	2.94
4. Thrombophlebitis	2	.60
Total	44	13%

5-1-56 with severe pre-eclampsia. She had had headaches, dizziness and epigastric pain for two weeks prior to admission.

On admission, her blood pressure was 250/160, pulse 100, and respiration 20. Chest was negative. Fundus was 26 cm, fetal heart tones in umbilical region, regular, good quality.

This patient was hospitalized from July 10, 1954, to August 4, 1954, for cerebral hemorrhage and hypertensive cardiovascular disease. The patient also had marked kyphosis due to tuberculosis of the spine (operated on in 1927).

On admission, the patient was treated with Serpasil and Apresoline intravenously for 24 hours without improvement. (Patient convulsed seven times.)

Under local anesthesia, an emergency cesarean section was performed. The infant weighed less than three pounds, and expired. Postoperatively, patient developed pulmonary edema and cardiac failure. Total urine output after the first 24 hours was 224 cc. Medical consultation was obtained and in spite of adequate medical management, the patient expired 48 hours after surgery. Post-mortem examination was not done.

Blood and urine chemistry results were as follows:

5-1-56: Urinalysis: Albumin 4+, reaction acid, sugar negative, granular casts 2+.
C.B.C.: Hematocrit 45%, RBC 5.2 million, Hgb. 15.3 gm. or 106% WBC 14,500.
5-2-56: Creatinine 16, NPN 48, total protein 5.75.
5-4-56: Chloride 89.8, CO_2 combining power 22.4, NPN 57.9, sodium 126.6.

Final Diagnosis: Eclampsia 6 months gestation. Hypertension. Cardiac decompensation.

Case D-2448

This 25-year-old gravida 4 para 3 had her last period on 11-1-57 and her estimated date of confinement was 8-8-58. She was admitted on 7-20-58 in coma. At another hospital she was diagnosed as having leukemia on 6-26-58 and was hospitalized four days. During her hospitalization, her white count was 134,000 to 176,000 and hematocrit was 25%. Two units of packed cells, and cortisone, were given.

Previous obstetrical history revealed all spontaneous deliveries at full term. Physical examination revealed: chest essentially negative, abdomen: vertex, enlarged to 28 cm. LOA position. Rectal examination: Floating, cervix closed. B.P. 140/80, pulse 102, respiration 20, temperature 102.

On admission, oxygen was given and a retention catheter was inserted into the bladder. A classical cesarean section was performed with oxygen anesthesia. Because of uncontrollable bleeding, a subtotal hysterectomy was also done. One unit of blood was given following the section and another unit postoperatively. The patient never recovered from her coma and expired three hours

TABLE 10.—*X-Ray Findings on C. P. D. Cases.*

YEAR	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	TOTAL
Number of C. P. D.	3	2	4	2	1	1	2	0	1	1	17
Inlet C. P. D.	2	1	0	1	3	4	2	2	1	3	19
Mid-plane C. P. D.	5	2	0	4	4	4	2	2	4	2	29
Outlet C. P. D.	1	0	0	0	0	1	1	0	0	0	3
Generally contracted pelvis	0	0	0	1	0	0	0	1	0	0	2
Deformity of pelvis	0	0	0	0	0	1	0	0	0	0	1
Total	11	5	4	8	8	11	7	5	6	6	71

after surgery. The infant weighed 5 lb. 1 ounce and was in good condition.

Final diagnoses at post-mortem examination were:

1. Leukemia, acute, monoblastic, involving bone marrow, lymph nodes, heart, lungs, spleen, liver, adrenals, kidneys, G.I. tract, brain.
2. Intracerebral hemorrhage, right, secondary to leukemia.
3. Postoperative status, 3 hours, cesarean section, and hysterectomy.
4. Effusion, mild, of pericardiac sac.
5. Splenomegaly, lymphadenopathy, and hepatomegaly secondary to leukemia.
6. Splenitis, acute, toxic.

Discussion

A study of the ethnic distribution among the section cases reveals that the Orientals, Portuguese, and part-Hawaiians predominate in this hospital. The majority of cesarean section cases were attended by the general practitioners. Repeat cesarean sections were performed without trial of labor. X-ray pelvimetry study revealed that the incidence of mid-plane contraction was higher than inlet or outlet contractions.

The highest incidence of cesarean sections was noted in the 21-30 age group.

Since 1959, some obstetricians are allowing trial of labor on previously sectioned patients. Up to the present, three cases have been delivered vaginally without postpartum complications; however, in one previous section case, trial of labor resulted in rupture of uterus so that a cesarean hysterectomy had to be performed.

The cesarean section rate is fairly low at this hospital, possibly due to the fact that this is a Catholic hospital where no postpartum sterilizations are done.

Summary

1. Three hundred thirty-nine cesarean sections performed during a ten-year period (1949-1958) at St. Francis Hospital were reviewed. The total number of deliveries during this ten-year period was 14,246. The incidence of cesarean sections was 2.37 per cent.

2. Low cervical section was performed on 287 cases or 84 per cent.

3. The major indications for cesarean section were: previous section (35 per cent); cephalopelvic disproportion (21 per cent); hemorrhage (19 per cent); abnormal presentation (12 per cent); toxemia (6 per cent).

4. The 118 repeat cesarean section cases were originally sectioned for the following four primary reasons:

a. Cephalopelvic disproportion .....61 cases 52%
b. Hemorrhage .....18 cases 15%
c. Toxemia of pregnancy .....15 cases 13%
d. Abnormal presentation and position..13 cases 11%

5. Type of anesthesia: 307 cases or 90 per cent were given spinal anesthesia.

6. There were 118 cases of repeat sections of which 84 per cent were sectioned twice.

7. Morbidity studies revealed an incidence of 13 per cent.

8. Maternal mortality rate for the ten-year period (1949-58) was 0.58 per cent. Corrected maternal mortality rate is 0.26 per cent.

Summario in Interlingua

Inter le 14.246 partos obstetric del annos 1949 a 1958 al Hospital St. Francis de Honolulu, 2,37 pro cento esseva complite per section cesaree. Inter istos, 84 pro cento esseva basse sectiones cervical. Plus que un tertio esseva indicate a causa de previe sectiones, un quinto a causa de disproportion cephalopelvic, un altere quinto a causa de hemorrhagia, un octavo a causa de presentation anormal, e sex pro cento a causa de toxemia. In plus que un medietate del repetitiones, le section original habeva essite indicate a causa de disproportion cephalopelvic, durante que in circa un sexto cata un le indication habeva essite hemorrhagia o toxemia; un decimo habeva essite indicate a causa de presentation anormal. Le mortalitate materne durante le periodo esseva 0,26 pro cento (un morte).

No. 110 Chun Chen Rd., Fung Yuen Chen

Jatropha curcas (kukui haole) seeds taste good—they say—

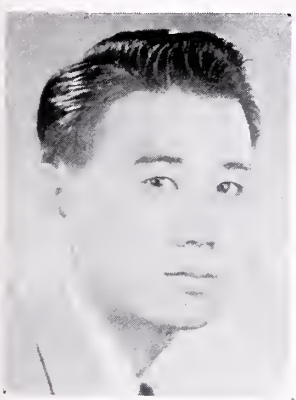
but contain dangerously powerful cathartics

Acute Poisoning From the Ingestion of Seeds of Jatropha Curcas

Report of Five Cases

RICHARD K. B. HO, M.D., Honolulu

THE INGESTION of plants and their products is responsible for a large portion of the calls to the Poison Control Center of Kauikeolani Children's Hospital. It is rare that active therapy is indicated, based upon our experience for the past year and one-half at the Poison Control Center; even the ingestion of known poisonous plants seldom leads to any severe symptoms.[1] Since 1951, only two cases of plant poisoning have been admitted to Children's Hospital, and seven over a five-year period between 1945-1950.[2] All of these children presented minor complaints. It is probably related to the fact that active toxic principles are present in such minute quantities that it requires the ingestion of large amounts of the poisonous plant to produce severe effects. However, we have had some recent experiences that seem to indicate this is not always the case and immediate treatment is sometimes indicated.



DR. HO

Fortunately, none of these cases terminated fatally, despite the fact that these plants belong to the same family as the castor bean, which is well known to everyone as being potentially lethal.[3] Prompt identification of any unknown plant or parts of a plant ingested is of utmost importance.[5] We intend to present five case histories below of patients we have recently seen or heard about that have ingested the seeds of the Jatropha curcas.

Case Reports

CASE 1: This 3-year-old Hawaiian-Caucasian boy was admitted to Kauikeolani Children's Hospital on September 20, 1958, because of persistent vomiting and diarrhea. The episodes were of sudden onset following the ingestion of several large black seeds gathered from an over-hanging branch of a neighbor's tree. He was unable to retain any ingested food or water. Each intake was vomited almost immediately after ingestion. The vomitus was said to contain the white granulated material and particles of the black shells. After several bouts of vomiting, the child started to have watery bowel movements. The stools contained the seed particles also. Three and one-half hours following the ingestion of the seeds,

Resident, Kauikeolani Children's Hospital.
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[1] Char, D. F. B.: Poison Control Center at Kauikeolani Children's Hospital. HAW. MED. J. 17:348 (Mar.-Apr.) 1958.

[2] Chun, L. T.: Accidental poisoning in children. HAW. MED. J. 11:83 (Nov.-Dec.) 1951.

[3] Oettingen, W. F. von: Poisoning: A guide to clinical diagnosis and treatment. Paul B. Hoeber, Inc., N. Y., 1952, p. 300. Arnold[4].

[4] Arnold, H. L.: Poisonous plants of Hawaii. Tongg Publishing Co., Honolulu, T. H., 1944, pp. 11-13.

[5] Wood, W. H.: Poisonous plants. J. Pediat. 50:499-505 (Apr.) 1957.

the child appeared lethargic. His skin felt cold and clammy. The child was admitted to the hospital in severe dehydration.

The family and past history were noncontributory.

Blood pressure was 100/70; pulse, 130; respiration, 40; temperature, 99.8° (rectal).

The patient appeared lethargic, cyanotic, and acutely ill. The peripheral vessels were constricted. Severe dehydration was indicated by the poor skin turgor, sunken eye balls, and deepening peri-orbital shadows. The bowel sounds were hyperactive. The remainder of the physical examination was within normal limits.

The hemoglobin was 14.2 gm/100 ml, the red blood cell count, 5.4 million, and the platelets were normal. The white blood cell count was 27,000 per cu mm, and the differential was normal. The urine showed a trace of albumin, and elements consisting of 2-4 white blood cells per high power field and many granular and some hyaline casts. The carbon dioxide level was 17 mEq per liter or 38 volumes per cent; sodium, 134 mEq per liter; chlorides, 101 mEq per liter; and potassium, 4.4 mEq per liter. The stool cultures were negative for pathogens.

The child was given 1,000 cc of homeolytic electrolyte solution. Blood was drawn for type and cross-matching. The patient was oliguric for the first 24 hours. He responded to treatment, and twenty hours after admission he was able to tolerate oral feedings without any vomiting or diarrhea, and was voiding well. He was discharged from the hospital after three days without complication.

CASE 2: This 3-year-old Portuguese-Filipino boy was admitted to St. Francis Hospital on September 24, 1958, with the chief complaint of diarrhea and vomiting. While he was playing with his siblings in a neighbor's yard, he ingested approximately ten black seeds taken off a tree. Soon after, he had dinner and promptly vomited five or six times. Almost simultaneously, brownish watery stools were passed. His father saw the particles of seed in the vomitus and feces. The patient became weak and lethargic. There was mild circumoral cyanosis and deepening periorbital shadows.

Blood pressure was 96/70; pulse, 132; respiration, 20; temperature, 98.2° F.

The patient appeared weak and somewhat drowsy. He was slightly dehydrated. Aside from the hyperactive bowel sounds, the physical examination was not remarkable.

Red blood cell count was 5.3 million, hemoglobin 14.4 gm per cent, a white blood cell count 23,600 per cu mm, and a normal differential count. The urine was normal. Stool cultures were negative for pathogens.

The patient was placed on a low fat diet and was given Donnagel, 3 tsp. every two or three hours until the diarrhea subsided. He had one watery stool and vomited twice after admission. He was discharged on September 26, 1958, completely recovered.

CASES 3, 4, and 5: These children were siblings of Case 2; an eleven-year-old girl, a four-year-old boy, and a two-year-old boy. The first two children were admitted to the same hospital for the same complaints and were treated similarly. The two-year-old child was said to have taken a bite into one seed and probably did not ingest any of it. He had one bout of diarrhea. He required no hospitalization or treatment.

Identification of the Plant

The above-mentioned seeds are from the Jatropha curcas. Common names are the physic nut tree, purging nut tree, big-purge nut tree, tuba, and many others, depending on the locale in which they are grown. In Hawaii, it is known as the kukui haole. It is a shrub or a small tree which may attain a height of 15 feet or more (Fig. 1). The fruit is about 3 cm in diameter and yellow in color when ripened (Fig. 2). The fruit generally dries on the plant to a dark brown roughened shell (Fig. 3). Within the fruit, there are three black seeds which are said to possess an agreeable taste. The blossoms consist of small yellow petals, and the leaves are stellate.



FIG. 1.—Jatropha curcas: Showing a branch of the tree. Note the blossoms at the end of the branch.

In the Far East, particularly in the Philippine Islands, the natives consider it a useful medicinal plant.[6] The leaves are used for snake bites, insect stings, boils, toothache, scabies, eczema, rheumatism, and ringworm. The seeds have served as an anthelmintic, but its use has been limited by its toxic effects.

The toxic principle, not unlike that of the castor bean, is a toxalbumin (curcin) and glycerides of acids similar but not identical to ricinoleic and crotonoleic acids. The following signs and symptoms may result from the ingestion of the seeds: severe vomiting and diarrhea, inflammation of mucous membranes, conjunctival hemorrhages, cyanosis, tachycardia, and hypotension. Oliguria or anuria may also result. No fatal cases have been reported locally, but the danger of "albuminoid poisoning" is always possible.[4]

In Hawaii, this tree is commonly found in relatively arid places, and next to homes because of its popularity with certain racial groups.

[6] Quisumbing, E.: Medicinal plants of the Philippines. Manila Bureau of Printing, Technical Bulletin No. 16, Republic of the Philippines, Department of Agriculture and Natural Resources, 1951, pp. 512-518.



FIG. 2.—Jatropha curcas: Ripe fruit opened to expose the black seeds.



FIG. 3.—Jatropha curcas: Dried fruit, the stellate leaf, and the individual seeds.

Summary

Cases of acute poisoning following the ingestion of the seeds of the Jatropha curcas are presented. Poisoning from toxic plants in Hawaii rarely leads to severe symptoms. However, the danger of severe toxicity is always present. The cases are presented to reemphasize this possibility and to acquaint physicians with a type of toxic plant in our midst.

Acknowledgements

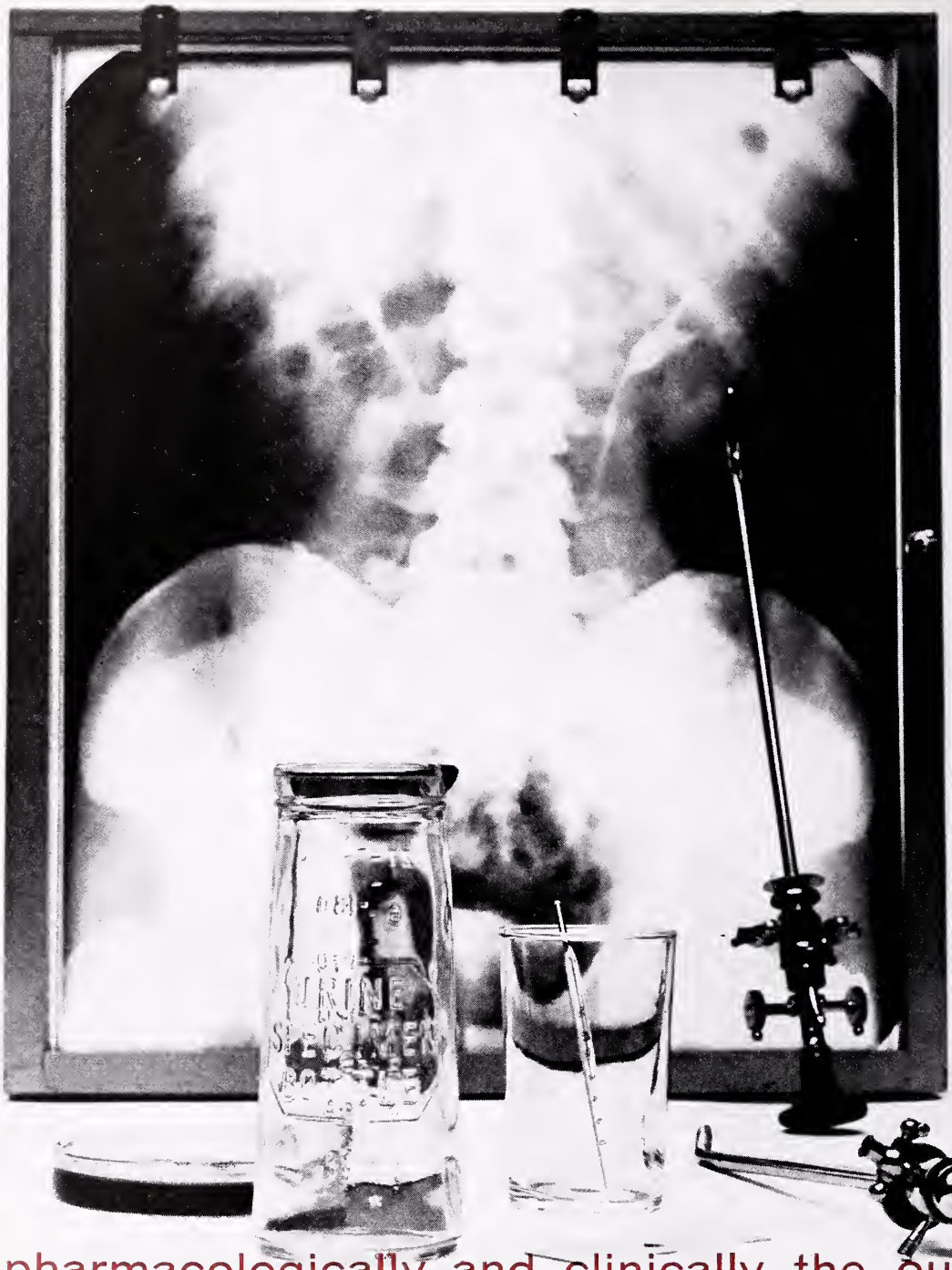
The author wishes to thank the University of Hawaii Department of Botany for their assistance in identifying the plant described above, and to Doctors John Felix, Robert Chung, and Kinsuke Nishimura for their permission to have the above cases reported, and to Doctor Donald Char for his helpful suggestions.

Addendum

Since the writing of this article, seven more cases (ages 3-6) of acute poisoning by a member of the Jatropha plant family, namely, the Jatropha multifida (Coral plant), were treated successfully at Children's Hospital. They indicate the similarity of toxins in plants of the same genus. Plants which bear fruit are attractive to children, and this may explain the relative frequency of poisoning from these plants.

Summario in Interlingua

Jatropha curcas (= nuce cathartic; in Hawai, *kukui haole*) es un attrahente e popular micre arbore ornamental. Su semine contine un potente toxalbumina, curcina, e etiam glyceridos de acidos que es simile a acidos ricinoleic e crotonoleic. On dice que su gusto es agradabile. Il occurre que infantes castica tal semines e deveni seriemente malade, con vomito, diarrhea, cyanosis, hypotension, e tachycardia. Oliguria o anuria es etiam effectos possibile. Cinque casos non-mortal de invenenamento a jatropha in juveniles es reportate. Nulle caso mortal ha cognoscitemente occurrite in Hawai.



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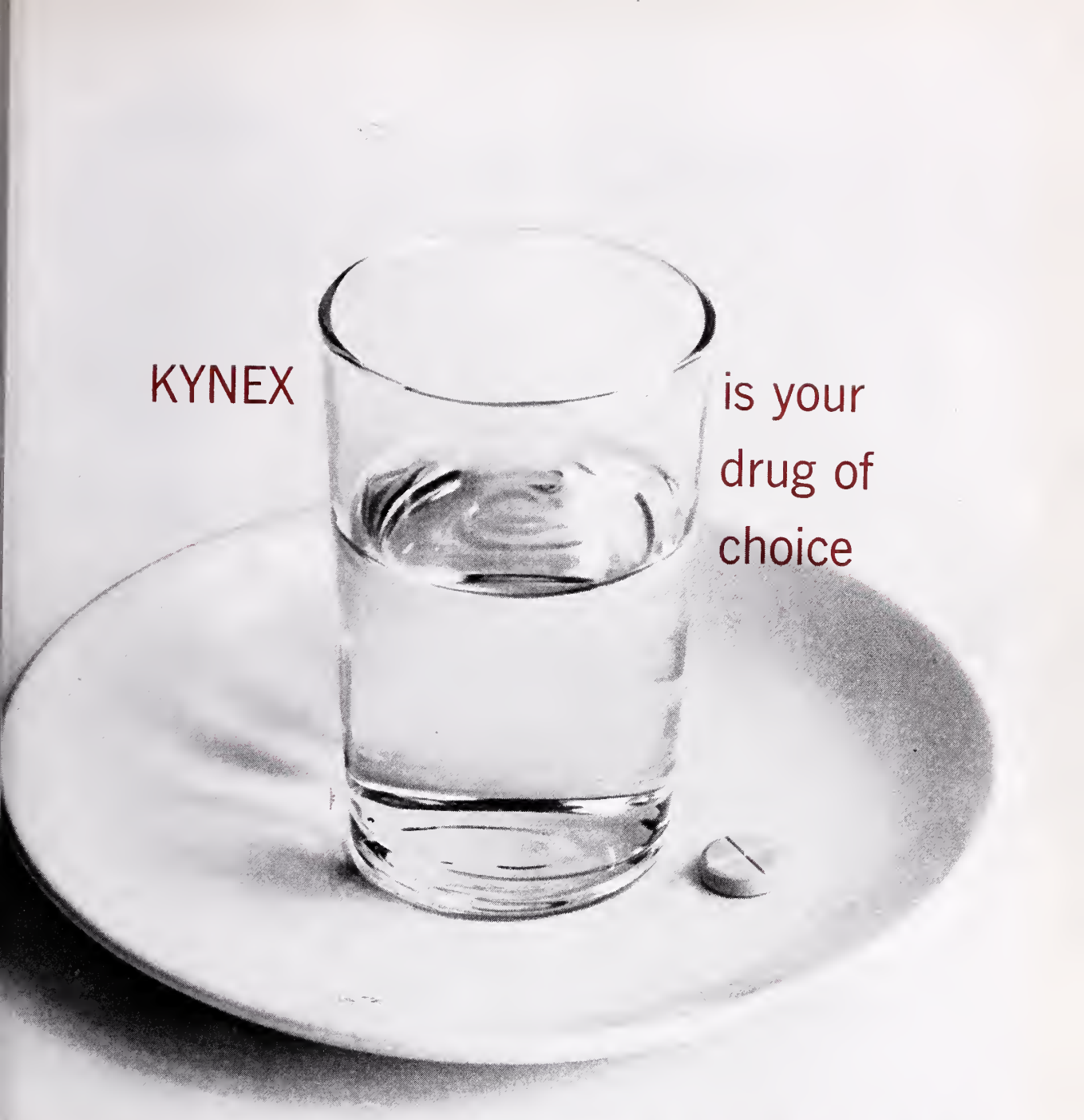
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



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The President's Page



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The die is cast.

By a surprising tie vote, 78 to 78, the membership of the Honolulu County Medcal Society denied themselves participation under Section 4(4-b) of the Federal Employees Health Benefits Program at a special meeting held on February 23, 1960. Denied also was the plea for official sanction which would have permitted HMSA to qualify under Section 4(4-b) and permitting individual participation to those physicians who might choose to do so.

For those who are fighting to maintain adequate fees, and the principle of being able to charge their patients what they see fit (therefore, the retention of an income clause) the action of the membership was a great victory—a victory in the sense that these recommendations were not overruled. But what have they contributed to the solution of the problem, except their statement of principles followed by conjecture as to what might happen if the membership failed to heed their words?

For the other fifty per cent of the membership who voted, it seemed a bitter pill to swallow. These members who are fighting to retain the patients they now have are sincere in their beliefs and efforts to offer something competitive, so that their patients might not be lost to a system of medical practice which the Society does not condone. Realizing the futility of fighting laws that have already been passed, they decided to make the best of an unfortunate situation.

All members agree that the physician has a right to charge what he chooses. They especially do not cherish government interference or third party intervention. However, it is my personal opinion that the Honolulu County Medical Society membership was very shortsighted in not permitting those who might wish to participate in the program under 4(4-b) to do as they please. The participating doctors would provide an experimental group to see how the plan works while necessary legislative efforts are being made to correct inequities, and at the same time provide a shock absorber for their patients.

After all—at this point no one can foresee the future or be certain what the correct solution is to this problem that confronts us. However, a decision has been made and will be respected.

The die has been cast.

T. Nishigaya, M.D.

P.S.—At the regular meeting held on March 1, 1960, a resolution permitting individual participation under Section 4(4-b) was passed by the Honolulu County Medical Society.

The die has been recast.

Hawaii
MEDICAL JOURNAL
OFFICIAL PUBLICATION OF THE HAWAII MEDICAL ASSOCIATION

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[EDITORIALS]

Cancer, Common Sense, and Bureaucracy

Section 409 of the Federal Food, Drug and Cosmetic Act got a new page in September, 1958. It had the following new paragraph:

> **Provided: That no additive shall be deemed to be safe if it is found to induce cancer when ingested by man or animal, *or* [italics added] if it is found, after tests which are appropriate for the evaluation of safety of food additives, to induce cancer in man or animal.**

Note the *or*. It means that either of these circumstances is enough to ban a food additive. "Appropriate tests" are not necessarily to be done.

This is the famous—the notorious, by now—"Delaney cancer clause." We have Representative Francis Delaney of Brooklyn to thank for it. The argument for it is as clear and simple as the argument against fluoridation. It goes like this: carcinogens can cause cancer; no one wants foods to cause cancer; therefore we don't allow carcinogens in foods. The fact that one might have to eat half a ton of the food daily for six months to get the carcinogenic effect is ignored.

Thus we find the Federal Government making a public spectacle of itself by banning crops of cranberries* because they contain traces of a weed killer which can cause cancer in rats. Ignored, by law, is the fact that this material is not known to be carcinogenic for humans in any quantity, and is surely not carcinogenic for anyone, rats or humans, in the amounts with which the user of cranberries on his Thanksgiving turkey is concerned.

In an ascending spiral of foolishness, we next find the Food and Drug Administration forbidding the sale of poultry caponized with stilbestrol. The fact that stilbestrol has been freely prescribed for many years in far larger amounts without being found to have caused a single case of cancer is just ignored. "Appropriate tests," you see, are not needed.

Next comes lipstick, containing a dye which has been found to produce cancer in some rats, if ingested. One could work out the approximate quantity required to cause cancer and warn the public against eating more than two, or four, or six lipsticks a day for longer than two, or four, or six weeks, as the case might be. Obviously the trace amounts of lipstick dye ingested by users would be of a far lower order of magnitude than the carcinogenic amounts—if, indeed, the dyes are carcinogenic for humans at all. Carcinogens are are curiously specific substances, sometimes.

So far, only food additives have been banned. Fowler's solution, cigarette smoke, sunlight, the charred surfaces of charcoal broiled steaks, and the recently identified carcinogen (for rats) isolated from egg yolk by Hradec at the Prague Oncologic Institute, are all still available for those of us who would live dangerously.

One wonders why the Department of Health, Education and Welfare would create these teapot tempests, and so harass cranberry growers, poultry raisers and cosmetic manufacturers. Could there be a political motive? Surely not; after all, the law is very clear, and they have no choice but to obey it.

The suggestion has been made that we might require manufacturers to prove their proposed additives are not carcinogenic. This specious suggestion seems to us, on inspection, absurd. How could it be done? How could one prove that the sodium benzoate in catsup is not carcinogenic? The only way to prove that something might happen is to prove that it has happened. There is no way to prove that it could not happen.

One can hope, however, that the future will

* In which we own no stock.—Ed.

bring a more sensible interpretation, if not a more sensible wording, of the law. The present wording and interpretation, in addition to making a lot of people unhappy and doing little good, seem calculated to discredit the F.D.A., and through it the Department of Health, Education and Welfare and even the Congress. A national authority is not immune to the fate which befell the boy who cried "Wolf!"

The Hawaii State Department of Health: a New Look

Some changes have been made in Hawaii's 120-year-old Health Department by the transition to statehood, and we thought you might be interested in a rundown on them.

The Director, Dr. Richard K. C. Lee, will have much more authority now, and more help. He will have a Deputy Director (Dr. Leo Bernstein, who is also Director of Local Health Services) and an Executive Assistant, and the Board of Health will serve the Department in an advisory instead of, as in the past, an administrative capacity.

There will be six staff offices, responsible to the Director: Business Management, Personnel Management, Health Education, Health Statistics, Hospitals and Medical Facilities, and Civil Defense Health Services. The medical care functions of the Bureau of Hospitals and Medical Facilities have been transferred (by a decision of the legislature) to the Department of Social Services (formerly Welfare).

Remainder of the Department is organized under six major Divisions: Dental Health, Hansen's Disease (leprosy), Sanitation, Local Health Services, Preventive Medicine, Mental Health (operation of the Territorial Hospital), and Mental Retardation (operation of Waimano Home).

Most of these Division names are self-explanatory, but not all. Included under Sanitation are the Bureaus of Industrial Hygiene (including radiation control), Mosquito Control, Pure Food and Drugs, Rodent Control, and Sanitary Engineering. Under Preventive Medicine are: Crippled Children, Epidemiology, Laboratories, Maternal & Child Health, Nutrition, Tuberculosis Control, and Alcoholism Clinic.

Transfer of the State's mental illness program from the old Department of Institutions to the Health Department is a forward step, in that it places all government mental health services in the one medical governmental department.

Transfer of the care of the indigent and medically indigent to the new Department of Social Services probably pleases few, at the moment, outside that Department; and we predict that it won't be long before it will please few *in* it. Medical care programs need medical administration; they are too complex to be handled by the rules of social service.

We think the State's public health problems are in capable hands, and that the inevitable fetters of civil service regulations will not keep these hands from doing the job we all want done.

The W.M.A. and the W.H.O.

The difference between the World Medical Association and the World Health Organization—wide as it is—is hard to keep straight. It matters to you, though, because you ought to join one of them and you can't join the other.

The one you ought to join—by paying $10 in annual dues to its United States Committee—is the World Medical Association, which was founded in 1948 by the A.M.A. You ought to join it because it depends on individual physicians' dues, and because its purposes are (1) the exchange of medical knowledge, (2) the protection of the freedom of medicine, and (3) the promotion of world peace.

Though you cannot join the World Health Organization, you are already supporting it, since the United States pays nearly two-fifths of its annual budget ($13,500,000 in 1958). Its members are the members of the United Nations. Its purpose is "the attainment by all peoples of the highest possible level of health," and some of its leaders think this includes compulsory health insurance.

Just to help you keep them straight:

	WORLD MEDICAL ASSOCIATION	WORLD HEALTH ORGANIZATION
Founded by	The A.M.A.	United Nations
Members are	Medical associations	National governments
Source of funds	$10/year dues	Taxes
Annual budget	$165,000	$13,500,000

Now would be a good time to write a check for $10—it's an income tax deduction—and send it to the World Medical Association, United States Committee, 10 Columbus Circle, New York 19, New York.

This is What's New!

Kirby and fellow workers report on the treatment of **staphylococcal septicemia** with **Vancomycin.** In staphylococcal septicemia 60 per cent of 33 patients so treated were cured. This compares favorably with the usual mortality of something over 50 per cent in spite of therapy with other antibiotics. In no instant did resistance to this bactericidal drug appear. Toxicity was rather low and consisted of chills, fever, and rashes. A dose of two grams a day, intravenously, was maintained for approximately two weeks. Incidentally, over half of these virulent staphylococcal infections were acquired in hospitals. (*New Eng. J. Med.* [Jan. 14] 1960.)

* * *

A **blood group chimera** has been produced in a patient by the use of a long-surviving **bone marrow graft.** The patient suffered from Hodgkin's disease with resultant pancytopenia. She received a bone marrow graft from her Rh positive sister. Ten months later her sister's graft continued to function with approximately 40 per cent of her circulating red cells arising from her sister's Rh positive marrow, while 60 per cent came from her own marrow. This is the first instance of a bone marrow graft surviving more than a month or so. (*Brit. Med. J.* [Jan. 9] 1960.)

* * *

Congenital aleukia (complete absence of white cells) is reported for the first time by a Dutch pediatrician. Identical male twins had had blood counts performed the day after delivery because they were doing poorly. No white cells were found in the peripheral blood. They **died of septicemia** on the fifth and eighth days of life, respectively. Bone marrow revealed no cells of the myeloid or lymphoid series. (*The Lancet* [Saturday, Dec. 19] 1959.)

* * *

Cavernous hemangiomas, or strawberry marks, when encountered in small children are best treated by **doing nothing,** says dermatologist Simpson after reviewing 140 children so afflicted. Over half of them disappear by the age of five years without treatment. Not so, says surgeon Brown. "In spite of preaching for years that a growing red spot on a baby's face is a **surgical emergency,** I have never yet had one referred to me at this stage by a general practitioner; but I have picked up a few and treated them." (*The Lancet* [Dec. 12] 1959 and [Jan. 2] 1960.)

* * *

The first impression was that the **81-year-old** Bostonian's penile lesion was a carcinoma; however, the second impression of **primary syphilis** was borne out by a dark field preparation teeming with Treponema pallidum. When interviewed for contacts, he reluctantly admitted sexual exposure with four different women during the previous three months. However, it was spring in Boston. His protocol indicates that he sought medical aid on May 26. (*New Eng. J. Med.* [Jan. 7] 1960.)

* * *

Eighty-four per cent of **teenagers** polled in a nationwide survey by Purdue University agreed that **oldsters in need of financial assistance** have the right to **expect help from their children.** Only 15 per cent thought that the Government should take care of the grandparents should they become ill or indigent. As usual, the American teenager is out of step with his times. (*A.M.A. News* [Feb. 8] 1960.)

* * *

The increased use of enzymes diagnostically has caused the *American Journal of Medicine* to devote an entire issue to a symposium on this subject. Some 20-odd **enzyme tests** are now used to assist the clinician in arriving at a diagnosis. Wroblewski of Sloan Kettering Institute is the Guest Editor. (*Am. J. Med.* [Dec.] 1959.)

* * *

The potent steroid diuretic, **spironolactone,** is now available in Hawaii. Detailed by Searle as Aldactone, it works by **blocking** the sodium-retaining action of **aldosterone.** This steroid-against-steroid effect results in sodium spillage with diuresis. One drawback is the cost—$4.00 a day as compared to 20 cents a day for hydrochlorothiazide. Although the Searle brochure advises Aldactone for five days (then, if adequate diuresis does not occur "a mercurial or thiazide diuretic should be added to the regimen") it probably should be the other way around, with spironolactone being reserved for **resistant edema.**

FRED I. GILBERT, JR., M.D.

FREEDOM
is never free...

In his keynote address last April to the 1959 Annual Conference of Blue Shield Plans in Miami, Florida, Robert R. Gros, vice president of Pacific Gas and Electric Company, San Francisco, quoted his good friend, Bernard M. Baruch's admonition "Preserving our freedoms is our most important job today . . ." and went on to say:

"I commend that theme to you ladies and gentlemen and myself this morning because in our perfectly understandable preoccupation with material success . . . you dare not forget that the greatest stake you have today is in preserving our American freedoms.

". . . let me remind you and myself that unless we do preserve these freedoms in the very precarious world in which we live, then the climate cannot exist in which my kind of industry and your kind of profession and, indeed, the business of sound, sensible, farseeing, practical hospital and medical and health plans can flourish. They can exist only within the framework and the climate of which freedom is a total prerequisite.

". . . the lawyers tell us that he who seeks equity must do equity. Similarly, public relations-wise, we must recognize that good public relations consists not of what we say but rather of what we do. Bluntly, to you medical gentlemen, I suggest a prerequisite before you can make a telling case in the public mind against socialized medicine on the traditional ground that it destroys the traditional doctor-patient relationship. You must examine and re-examine your own individual situation to make a hundred percent sure that this doctor-patient relationship still exists in your own practice."

Blue Shield Plan for Hawaii



HAWAII MEDICAL SERVICE ASSOCIATION

Member, Western Conference of Prepaid Medical Service Plans

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In Memoriam -- Doctors of Hawaii -- XXV

This is the Twenty-fifth installment of In Memoriam—Doctors of Hawaii.

William Blamyer Deas

William Blamyer Deas was born in 1868. His medical education was received at Cooper Medical College, from which he graduated in 1889.

In 1902 Dr. Deas was government physician at Heeia, Oahu. By 1907 he had moved to Hana, Maui, where he practiced until 1915. In 1923 he was in practice in San Francisco, and by 1931 he was with U. S. Veterans' Bureau. He continued to serve with the Veterans' Administration in San Francisco until his retirement. After retiring in 1940, the doctor made his home in Alexandria, Virginia.

Dr. Deas died in Augusta, Georgia, January 19, 1941, at the age of 72.

He was a World War I veteran and, during his years in the Islands, was a member of the Hawaii Medical Society.

Robert Henry Dinegar

Robert Henry Dinegar, born in 1870, was a graduate of the New York University Medical College in 1892.

Dr. Dinegar was in practice on Maui for ten years. He began his practice at Kihei in 1900 where he served as government physician and as physician for the Hawaiian Commercial and Sugar Company. In 1904 he located at Puunene where he remained until 1907 when he moved to Wailuku.

The doctor made the newspapers in June, 1904, when he became the first physician to import radium into the Territory. The same story reports that he had experimented successfully with an x-ray machine presented to Puunene Plantation Hospital and concludes, "now he will try to effect cures by use of the much-heralded radium." He is also remembered by old-time residents as having the second car on Maui, an Oldsmobile.

In 1910 Dr. Dinegar moved to New York. He established a practice limited to roentgenology in Albany, New York, and was on the staff at St. Peter's Hospital.

On July 29, 1930, Dr. Dinegar died in Albany at the age of 59.

He was a member of the American Medical Association, the American Roentgen Society, and the Radiological Society of North America. During his days on Maui, he was a member of the Hawaii Medical Society.

Katherine Joanna Mackay

Katherine Joanna Mackay was born in Plainsfield, Nova Scotia, in 1867.

In 1890 she graduated as a nurse from the New England Hospital for Women and Children in Boston, Massachusetts. From nursing she turned to medicine and in April, 1895, received her M.D. degree from Dalhousie University at Halifax, Nova Scotia.

In 1896 Dr. Mackay went into practice with her brother, Hector H. Mackay, M.D., C.M., in New Glasgow, Nova Scotia. She came to the Islands in 1900 and she served on the staff of The Queen's Hospital in Honolulu until she was licensed to practice medicine and surgery in the Territory in December of the same year. The following year Dr. Mackay was appointed medical examiner for the U. S. Insurance Companies at Hilo, Hawaii, and at the same time carried on a private practice.

The doctor returned to the Mainland in 1902 or 1903. While the exact date of her departure is not known, she probably sailed on the "Ventura" on November 11, 1902. It was on this return voyage that Dr. Mackay met Queen Liliuokalani, and the chance shipboard meeting ripened into a friendship which was kept alive through letters until the queen's death. The doctor's family still has gifts which Queen Liliuokalani sent to her friend.

In 1903 Dr. Mackay married J. R. MacKenzie in Vancouver, British Columbia. On her return to Canada, Dr. Mackay practiced first at Strathcona Hospital at Edmonton, Alberta. In May, 1908, she was licensed to practice in the province of British Columbia and practiced in Vancouver until her death in 1923 at the age of 56.

Walter Remsen Brinckerhoff

Walter Remsen Brinckerhoff graduated from Harvard University in 1897 and from Harvard Medical School in 1901. Dr. Brinckerhoff interned and then served as second assistant and first assistant in pathology at the Boston City Hospital.

In 1902 he was made assistant in pathology at Harvard University and in 1904 he became a fellow of the Rockefeller Institute of Medical Research. The following year he was appointed physician to the Carnegie archeological expedition to the Transcaspian Territories.

Dr. Brinckerhoff came to Honolulu in 1905 under appointment to the U. S. government to assume charge of the leprosarium at Molokai. Prior to coming here he had been investigating leprosy in Manila.

On August 21, 1906, Dr. Brinckerhoff married Nellie White, a sister of Mrs. James B. Castle, at the Castle home in Honolulu. On April 1, 1909 Mrs. Brinckerhoff died, leaving a newly born son.

Dr. Brinckerhoff left Honolulu in July, 1910, for Boston where he became Assistant Professor of pathology at the Harvard Medical School.

Shortly before his death, Dr. Brinckerhoff went to Washington, D. C., at his own expense to make a statement to Representative Tawney with reference to the leprosy investigation work in Hawaii. He told of the accomplishment of Dr. Currie in growing the bacilli of leprosy and asked that Congress appropriate liberally for leprosarium work. Dr. Brinckeroff worked with Drs. Hollman and Currie in the first group to confirm Moses Clegg's method of cultivating bacillus of leprosy outside the human body.

Dr. Brinckeroff died March 2, 1911, in Jamaica Plain, Boston, at the age of 36.

He was a member of the Massachusetts Medical Society, American Association of Pathologists and Bacteriologists and the Society of Experimental Medicine. While he was in Honolulu he was president of the Men's Club of St. Andrew's.

Book Reviews

Physiopathology of the Reticulo-Endothelial System

Edited under the direction of B. N. Halpern, 317 pp., $9.00, Charles C. Thomas, 1937.

A group of skilled investigators presents 17 papers on the reticulo-endothelial system. Each paper is followed by a discussion. There are French, Swiss, English, German, and American contributors. The subjects are as widely dispersed as the reticulo-endothelial elements themselves. Iron metabolism, hematoclasia, cholesterol metabolism, phagocytosis, hypersensitivity reactions, and local defenses against infection are covered in great detail. There is much highly refined information in this volume that ordinarily would have to be sifted from a multitude of separately published articles. This is an excellent source book for those who want to get down to the fine points.

GRANT N. STEMMERMANN, M.D.

★ Clinical Endocrinology, 2nd Ed.

By Karl E. Paschkis, M.D., Abraham E. Rakoff, M.D., Abraham Cantarow, M.D., 941 pp., $18.00, 1958.

All the endocrine glands including the placenta are discussed in terms of their anatomy, normal physiology, hyperfunction, and hypofunction. A section on obesity is included with its endocrine and nonendocrine aspects.

The best and most worthwhile section is that on Procedures and Methods of Study. Hormone assay methods, and normal and abnormal levels, are very well described. This is a sorely needed chapter.

New knowledge is rapidly expanding in the complex field of endocrinology. This book brings us very nearly up to date.

NOBUYUKI NAKASONE, M.D.

★ Synopsis of Ear, Nose, and Throat Diseases

By Ryan, R. E., Thornell, W. C., and Von Leden, H., 383 pp., $6.75, The C. V. Mosby Co., 1959.

Drs. Robert E. Ryan, William C. Thornell, and Hans von Leden have produced a most practical synopsis of ear, nose, and throat diseases.

It is easy to read. It is accurate and logical from start to finish. It is really a very comprehensive digest containing far more than the title implies and is enjoyably free of those repetitious somethings so often found in text books.

They haven't tried to cover the waterfront, yet somehow they have.

I recommend it to every physician, general and specialist alike.

F. J. PINKERTON, M.D.

Patient Care and Special Procedures in X-Ray Technology

By Carol Hocking Vennes, R.N., B.S., and John C. Watson, R.T., 203 pp., $5.75, The C. V. Mosby Co., 1959.

There are few texts of actual procedures and positions in the taking of x-rays. This book fills a gap, giving a formal presentation and reference to assist in integrating the patient's overall medical care. X-ray training is usually divorced from nursing care, and as a result this portion of the technician's role is at times neglected.

The author goes into great detail, albeit sometimes repetitive, about the proper management of patients who are to have x-ray examinations and studies. He points out many fields where friction and difficulties can be avoided if thought is given to the patient's care ahead of time.

Ideally all x-ray technicians ought to read the complete book. It is highly recommended that chief technicians of any hospital or private office should read the complete book, and have it available for reference. The greatest value will be obtained by the radiologist and chief technician who are teaching student x-ray technicians. In addition, the chief nurse and nursing supervisor of each hospital will find this of value. As well as many educational points for x-ray technicians, there are many items that the nursing profession would find helpful. In addition, most radiologists will find suggestions to help make their departments run more smoothly.

GEORGE W. HENRY, M.D.

Epilepsy Handbook

By Frederic A. Gibbs, M.D., and Frederick W. Stamps, M.D., 101 pp., $4.75, Charles C. Thomas, 1958.

This book is a practical summary of present knowledge of the diagnosis and treatment of epilepsy as viewed from the clinical and electroencephalographic standpoints. It should be a part of every doctor's library since it so readily and lucidly orients one to what is known today about this difficult field. I strongly recommend it to every general practitioner, internist, neurologist and psychiatrist. There is a very clear delineation of the essential clinical forms of epilepsy, the clinical findings and symptomatology, and the electroencephalographic correlations in a simple, readily understood presentation.

J. ROBERT JACOBSON, M.D.

★ Treatment of Breast Tumors

By Robert S. Pollack, M.D., F.A.C.S., 147 pp., $6.00, Lea & Febiger, 1958.

Beginning with chapters on the classification of benign breast tumors, the physiology allied thereto, and appropriate medical and surgical management, the author then devotes the remainder of the book to the many problems of diagnosis, anatomy, and treatment of mammary cancer. Included are sections concerned with definitive surgery, irradiation therapy, combined management, and end results of therapy for primary manageable breast cancer. Finally, the irradiation, glandular ablative, and chemotherapeutic management of more advanced problems complete the book.

Although, this is a small book, dealing with an enormous subject, the author has managed to fulfill his purpose to "to broaden our knowledge of breast cancer" adequately. Inspite of its brevity, it represents a remarkably complete summary of present day concepts of breast tumors and their management. It is recommended to all

(Continued on page 462)

★ Highly recommended.

Infant Death Case Studies Nos. 4 and 5

A male infant who weighed 7 pounds at birth was delivered to a 22-year-old married Hawaiian mother at 36 weeks' gestation. She had had two uneventful pregnancies. The mother kept her antepartum appointments and gained a total of ten pounds. Her pelvis was considered to have a somewhat small inlet, with average outlet, android type. Three weeks before delivery, breech presentation of fetus was converted by external version. One week later it was again in breech position. The infant was delivered in a rural hospital after ten hours of labor. It was a breech presentation (footling). Piper forceps were applied with great difficulty to the after-coming head, and strong pulling was necessitated. The mother received "whiffs of ether" during head extraction.

The baby was in "very poor condition" at birth. He was resuscitated by a long period of mouth-to-mouth breathing and was put in an incubator with 40% oxygen. One ampoule lobeline and one-half ampoule caffeine sodium benzoate were given. The infant followed a downhill course and died the second day. The death certificate gave the cause of death as intracranial hemorrhage. No autopsy was performed.

A female who weighed 7 pounds and 2 ounces at birth was delivered to a 32-year-old married Japanese primipara who had an uneventful pregnancy under routine care. Pelvic x-ray one day prior to delivery showed an apparently normal, gynecoid pelvis. She entered a rural hospital in active labor. A double footling presented after thirteen hours. Two hours after full dilatation of the cervix a sterile pelvic examination was done and membranes ruptured. One foot delivered. Breech delivery under open drop ether proceeded smoothly until the head was ready to deliver. It could not be delivered because of "tightness of vaginal tissues." Piper forceps were applied to the head with great difficulty and slipped off three times. The head would not come through with strong pulling and pressure from above.

When finally delivered, the left side of the head was crushed in and fractures of the parietal bones could easily be felt. The baby was resuscitated with a few minutes of intratracheal oxygen. The infant seemed good for the first six hours, then respirations slowed and ceased at eight hours of age. The physician stated in a letter to the Committee that the next footling would be done by cesarean and that he should have done a cesarean on this patient because she was a 32-year-old primipara.

Discussion: These two cases were discussed jointly because of some common aspects. Questions raised were: Was the cervix really well dilated, and was the episiotomy adequate? The Committee agreed that Piper forceps should not be used for "lifting out" or "hard pulling."

It was also agreed that a breech delivery is a major obstetric complication and consultation should be requested. Consultation can be arranged through the State Bureau of Maternal and Child Health by telephone on the request of the attending physician for any area in the State. If the patient cannot pay, the consultation fee will be paid by the Bureau.

The Committee commented on the attending physician's feeling that he should have done a cesarean on a 32-year-old primipara. The Committee did not feel that cesareans should be recommended for footlings or for 32-year-old primiparas in general.

The desirability of autopsies on all infant deaths was again emphasized.

Classifications: No. 4 was considered an obstetric infant death, preventable from a practical standpoint, with primary factors of preventability being errors in judgment, lack of consultation, and probably lack of facilities.

No. 5 was also considered an obstetric death, preventable, with primary factors being errors in judgment and technic, lack of consultation, and possible lack of personnel to assist with the delivery.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

Notes and News

New Faces and Places

Dr. Angie Connor is chairman of the Governor's committee on mental retardation. Other members are **Dr. George Stevenson** and **Dr. Harold Sexton.**

Dr. Frank S. Akamine announced his association with the Central Medical Clinic.

Dr. Lawrence Y. W. Wong has opened his office in Kaimuki and **Dr. Gordon E. Nielson** opened new offices in Laie.

Dr. George F. Schnack will head a new mental health clinic at Lanakila Health Center, and **Dr. Leo Bernstein** is the new deputy director of the State Department of Health.

The 1960 roster of the top officers in the Honolulu County Medical Society are: President: **Dr. H. Q. Pang;** President-Elect: **Dr. A. S. Hartwell;** Secretary: **Dr. O. D. Pinkerton;** Treasurer: **Dr. R. D. Moore.**

The Speechmakers

In January **Drs. Leabert R. Fernandez, Philip J. W. Lee, Walter B. Quisenberry,** and **Roy T. Tanoue,** with **Dr. Claude V. Caver** as moderator, enlightened the public regarding cancer. Their subject, "New Hopes—After Cancer" was presented at Mabel Smyth Auditorium. In February the same moderator assisted by a panel consisting of **Drs. L. Q. Pang, Masato Hasegawa, Robert P. C. Ho,** and **Nils P. Larsen,** helped educate the layman regarding Wheezes, Sneezes, and Sniffles, following a Walt Disney movie "How to Catch a Cold." An excellent quote to remember and use on the proud mamas of over-fed youngsters is this one expressed by Dr. Hasegawa during this forum. "Fat babies are not the ultimate," he said. "Big healthy brain cells are the important thing!"

Early in January **Dr. William E. Mayer** spoke to the Hui O Wahine at Fort Shafter on the important role women play in the lives of their husbands and children. Later in the month he spoke on "The Significance of Communistic Indoctrination in American Education" at Kalani High School.

Participating in the Governor's Institute on Rehabilitation were **Drs. Richard K. C. Lee, Toru Nishigaya,** and **R. Frederick Shepard.**

Honors

Dr. Morton E. Berk was appointed to the board of directors of the American Heart Association.

Dr. William J. Holmes has written a new book, "Night Vision."

Dr. Richard W. You has been appointed to the Executive and Foreign Relation Committees of the National A. A. U.

Dr. Duke Cho Choy tied for first place in the Waialae Country Club medal tournament with a score of 77-10-67.

New Business

Drs. H. Q. Pang and **Toru Nishigaya** are directors in the new Diamond Head National Life Insurance Company.

PAUL LEIGHTON LEYDA, JR., A.B., M.D.
1923-1959

Paul L. Leyda, Jr., was born in Denver, Colorado, January 30, 1923, the son of Dr. Paul Leighton Leyda and Edythe Leyda. He was educated in the Denver Public Schools, and obtained his B.A. degree from the University of Denver. He graduated from the University of Colorado School of Medicine in April, 1946.

After an internship at the Highland (Alameda County) Hospital, Oakland, California, he took residency training in general surgery at the U.S.V.A. Hospital, Denver, Colorado, and was certified by the American Board of Surgery in 1955.

Doctor Leyda married Miss Jeanne Gifford of Denver on December 23, 1947. The couple had three children, John, Kent, and Elizabeth.

Doctor Leyda served in the U. S. Army Air Corps from 1947 to 1949, attaining the rank of Captain.

Following completion of his surgical residency he took a position as surgeon in the U.S.V.A. Hospital at Grand Junction, Colorado. He came to Hawaii in September, 1954, and entered practice on the Island of Lanai, where he stayed for one year. After a brief experience as a U.M.W. surgeon in Kentucky, he joined several colleagues with whom he had interned, and enjoyed a successful clinic practice in Hayward, California. Shortly thereafter he became ill, and spent several months in hospitals.

In the summer of 1958, Doctor Leyda returned to Hawaii, and, after practicing a few months in Wahiawa, joined the Fronk Clinic Staff in Kahuku. He again became ill and returned to his former home in Denver, where he died unexpectedly on February 24, 1959.

Doctor Leyda's untimely death was mourned by countless friends he had made in Hawaii as well as in California and Colorado.

He was a member of the Hawaii Medical Association, A.M.A., and Nu Sigma Nu medical fraternity, and a Diplomate of the American Board of Surgery.

In addition to his widow and three children, he is survived by his mother, Edythe Leyda of Denver, and two sisters, Mrs. Mary Pearson of Denver, and Mrs. Betty Cedarblade of New York.

F. B. WARSHAUER, M.D.

High Society

Dr. Claude V. Caver and Miss Audrey I. Kimm were married on December 19, 1959.

Dr. Blaine Boyden, who is taking his residency in New York, spent Christmas with his parents, Dr. and Mrs. Webster Boyden of Lihue.

Dr. Garton Wall and his family enjoyed skiing at Sun Valley, Idaho, over the holidays.

New Appointees

To the Board of Medical Examiners—**Drs. Harry L. Arnold, Jr., Kikuo Kuramoto, B. Allen Richardson, Samuel L. Yee** (Oahu), **Patrick Cockett** (Kauai), and **Francis Wong** (Hawaii), and **Seiya Ohata** (Maui).

To the Board of Health—**Drs. Marvin A. Brennecke, Isaac Kawasaki, Richard D. Moore, L. Q. Pang,** Messrs. Charles Arthur Lyman, Aaron G. Marcus, A. L. Y. Ward, Mesdames Chiyono Kobayashi, and Eva Muller.

Medical Association of Hawaii

From *The Journal of the AMA:*
Association News—June 16, 1900.

Dr. Bulkley, speaking for the General Executive Committee, said: With reference to the report of the secretary, which was referred to the General Executive Committee, it was referred to a subcommittee, and this subcommittee reported that there was nothing in it requiring special action. But a very important matter has been overlooked, viz., application for membership by members of the Medical Association of Hawaii, who are subscribers to *The Journal,* and who wish to become members. Now, we have an Executive Council, and I move you, sir, that this matter, which was overlooked, be referred to the Executive Council with power. Seconded by Dr. Reynolds, Louisville.

Dr. Happel, Tennessee, said that, if he was not mistaken,* Hawaii is a possession of the United States. This being so, the Constitution provides for the admission of such members whose societies are in affiliation with the American Medical Association.

The secretary stated that this organization in Hawaii was not affiliated with the American Medical Association. It is not recognized by any state society, and he asked that he be given authority to indorse the Medical Association of Hawaii.

Dr. Happel said that the Constitution provides, if that society is not in affiliation with the American Association, then it shall send its Constitution and By-Laws to the Chairman of the Judicial Council, who will examine them and report to the secretary of the Association whether or not they accord with the requirements of our law. If the society is in affiliation with the Association, the secretary will then be authorized to receive them.

Hawaii Delegates to the American Medical Association • 1904-1960

1904—Charles B. Cooper
1905—J. T. Wayson
1906-1908—No delegate present at meeting.
1909—A. G. Hodgins
1910-1914—No delegate present at meeting.
1915—Charles B. Cooper
1916-1918—No delegate present at meeting.
1919—A. N. Sinclair
1920—No delegate present at meeting.
1921—J. T. McDonald
1922—Charles B. Cooper
1923—No delegate present at meeting.
1924—F. E. Trotter
1925-1926—No delegate present at meeting.
1927—Harry L. Arnold, Sr.
1928—No delegate present at meeting.
1929—Charles B. Cooper
1930—F. E. Trotter
1931—Harry L. Arnold, Sr.
1932—F. J. Pinkerton
1933—G. M. Van Poole
1934—Alfred L. Craig
1935—No delegate present at meeting.
1936—G M. Van Poole
1937—F. J. Pinkerton
1938—F. J Pinkerton
1939—F. J. Pinkerton
1940—No delegate present at meeting.
1941—F. J. Pinkerton
1942—No delegate present at meeting.
1943—F. J. Pinkerton
1944—F. J. Pinkerton
1945—Aaron Sumner Price
1946—F. J. Halford
1947—Arthur N. Wilson
1948—F. J. Halford (January Interim Session)
—F. J. Pinkerton (Annual & November Interim Sessions)
1949—F. J. Pinkerton
1950—Alfred S. Hartwell
1951—Alfred S. Hartwell
1952—Alfred S. Hartwell
1953—Alfred S. Hartwell (Annual & Clinical Sessions)
—A. Leslie Vasconcellos (Special Session)
1954—Homer M. Izumi
1955—Homer M. Izumi
1956—Harry L. Arnold, Jr.
1957—Harry L. Arnold, Jr.
1958—Harry L. Arnold, Jr.
1959—Harry L. Arnold, Jr.
1960—Harry L. Arnold, Jr.

* He was. Hawaii became an incorporated Territory of the United States in August, 1900.—Ed.

County Society Reports

Hawaii

The December meeting and annual party of the Hawaii County Medical Society was held at the Hilo Yacht Club on December 11, 1959. Twenty-five members and their wives and five guests were present.

Dr. Toru Nishigaya, paying his annual visit to the Hawaii County Society, informed the members of certain problems currently facing the state medical society.

The evening was concluded on a lighter note with Dr. Henry Yuen acting as Master of Ceremonies. The members spent the rest of the evening with games and group singing, and thoroughly enjoyed themselves.

The following members have been elected to office for 1960: President, Dr. Richard Hata; Vice-President, Dr. Samuel Haraguchi; Secretary, Dr. Tokuso Taniguchi; and Treasurer, Dr. William Davis. Dr. David Woo has replaced Dr. Steuermann as the delegate to the H.M.S.A.

* * *

The first 1960 meeting of the Hawaii County Medical Society was held on January 14 at the Hilo Hotel. Members present were Doctors George Tomoguchi, Pete Okumoto, Nick Steuermann, S. Kasamoto, Richard Hata, T. Taniguchi, Robert Miyamoto, Z. Matayoshi, R. P. Wipperman, T. Oto, Samuel Haraguchi, and T. Kutsunai.

The meeting was called to order by president Richard Hata. The matter of the annual A.A.P.S. (American Association of Physicians and Surgeons) essay contest was brought up. The members decided to sponsor the contest again this year and to award prizes similar to those given last year.

Mr. Veltmann and Dr. Nishigaya explained to the members of the Society about the government sponsored Medical Care Program for Federal Employees—Public Law 86-382. The members decided to go on record in favor of having HMSA qualify for Plan 4-B with an income clause; however, if this is not available, to have HMSA qualify for Plan 4-B without the income clause.

Mr. Stanley Nakamae of the First Trust Company of Hilo gave an informative talk on stocks and bonds, supplemented by a twelve minute motion picture film produced by the New York Stock Exchange.

TOKUSO TANIGUCHI, M.D.
Secretary

Honolulu

The Honolulu County Medical Society held its annual membership meeting on Tuesday, December 8, 1959, in the Mabel Smyth Auditorium. The meeting was called to order by Dr. Thomas H. Richert at 7:40 P.M. Approximately 120 members were present. The minutes of the special meeting held December 1, 1959, were approved as summarized by Dr. Hartwell. Dr. George D. Oakley and Capt. Wilbur S. Lummis were welcomed into the Society as new members.

Dr. Chalmers, Chairman of the Nominating Committee, presented the committee's slate of nominations for officers and elected committees which had circulated to the membership prior to the meeting.

Election of the various officers and committees was held in the following order, interrupted at intervals by the reading of annual reports:

Election results were announced by the Chair, as follows:

A. S. Hartwell, *President-Elect*
O. D. Pinkerton, *Secretary*
Richard D. Moore, *Treasurer*

Board of Governors (2 years)
George H. Mills
R. Allen Richardson
R. Varian Sloan
Randal Nishijima (1 year)

Alternate Board of Governors
Thomas P. Frissell
John Ohtani
William H. Stevens

Representatives to HMSA
Herbert Y. H. Chinn
John P. Frazer

Alternate Representatives to HMSA
Leabert R. Fernandez
Yasuyuki Fukushima
Paul Gebauer
Warren L. H. Wong

Fee Adjustment Committee
Robert G. Hunter
Herbert G. Pang

Medical Care Plans Committee
Takeo Fujii
John I. F. Reppun

Board of Censors
Henry C. Gotshalk

Medical Practice Committee
Richard E. Ando
John J. Lowrey

Nominating Committee
Andrew L. Morgan
Verne C. Waite

Delegates to HMA
Morton E. Berk
Harold M. Johnson
George H. Mills
Andrew L. Morgan
Walter S. Strode
Thomas H. Richert
Paul Y. Tamura
Verne C. Waite
James T. S. Wong

Alternate Delegates to HMA
Grover H. Batten
Charlotte M. Florine
Bernard W. D. Fong
Unoji Goto
Allan Leong
Pershing Lo
William F. Moore
Kaoru Sasaki
Clarence Y. Sugihara
William H. Wilkinson

The annual reports were presented as follows:

Resolutions Committee—Dr. Edwin K. Chung-Hoon
Constitution & Bylaws Committee—Dr. Robert T. Wong
Advisory Committee to the Woman's Auxiliary—Dr. Herbert G. Pang
Woman's Auxiliary to the HCMS—Mrs. George B. Garis
Legislative Committee—Dr. Leabert Fernandez
Public Service Committee—Dr. Claude V. Caver
Program Committee—Dr. George W. Henry
Postgraduate Committee—Dr. Verne C. Waite
Medical Care Plans Committee—Dr. Richard D. Moore
HMSA Medical Committee—Dr. John P. Frazer
Fee Adjustment Committee—Dr. E. F. Cushnie
Medical Practice Committee—Dr. H. Q. Pang
Board of Censors—Dr. William M. Walsh
Medical-Legal Committee—Dr. Harold Civin
Executive Secretary's Report—Mr. R. M. Kennedy
Treasurer-Finance Committee—Dr. O. D. Pinkerton
Secretary's Report—Dr. A. S. Hartwell
President-Elect's Report—Dr. H. Q. Pang

Regarding to the Legislative Committee report which mentioned that the Honolulu County Medical Society makes no budgetary appropriation for their committee, Dr. Richert stated that it is hoped a budget can be set up for the committee to work with especially to handle the problems arising during the next legislature. He also mentioned that it is hoped that Mr. Kennedy and Mrs. Devereux will also be able to keep the profession advised of legislation affecting the medical profession.

Following the Treasurer's report, Dr. Ando questioned the section which mentioned that the Medical Library had been overpaid by $1,106.24 in membership dues because of our change from a fiscal year to a calendar year and that a request will be made for either a refund or a deduction in next year's dues. Dr. Ando stated that it was his understanding the Honolulu County Medical Library sets the dues and the Board of Governors of the Honolulu County Medical Society approves it and that approval of the 1959 budget approved a set sum beyond the figure that the treasurer reported.

It was explained by the chair that there is nothing in our Constitution and Bylaws which stated that the Society shall donate any set amount and that the Society allocates a portion of the Society's dues to the Library according to the need. How much is allocated is up to the Board of Governors and the membership.

(Continued on page 452)

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It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

When Aldactone is used in a comprehensive therapeutic regimen, which includes a mercurial or a thiazide diuretic, a satisfactory diuresis and relief of edema may be expected in approximately 85 per cent of edematous patients *who would not otherwise respond.*

DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

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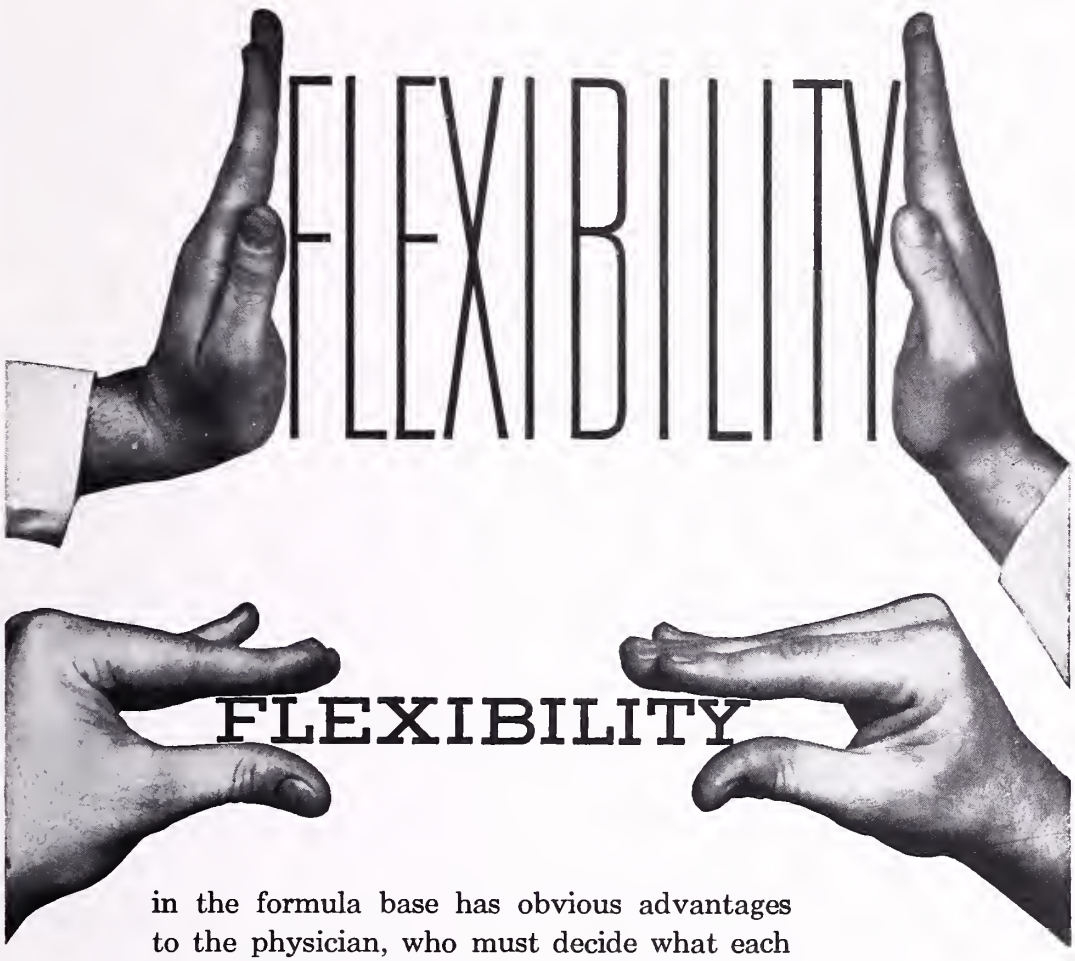
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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

ROSIE CHANG, *Editor*

FLORA OZAKI, *Associate Editor*
KATSUKO ENOKI, *Associate Editor*
HAZEL KIM, *Associate Editor*
MILDRED KIM, *Associate Editor*

OLIVE C. PRIDGEN, *Executive Secretary*

General Interest

Will *You* Pay Two or Seven Dollars To Register Your License to Nurse?

It's up to you. If you are late in registering your license to nurse, it will cost seven dollars to be reinstated after June 30, 1960. The 1959 revision of the nursing practice law authorizes an additional penalty fee of five dollars for late registration and licenses registered this year expire June 30, 1960.

To quote Chapter 67, Section 16 Revised Laws of Hawaii:

> The license of every person engaged in nursing in the Territory of Hawaii under the provisions of this chapter shall be valid for the period July 1 through June 30, and shall be renewed annually. The applicant shall file an application with a renewal fee of $2 on or before June 30 of each year.
>
> Licenses which are not so renewed by July 1 are subject to penalty of $5, unless prior to July 1 the holder notifies the board in writing of intent not to practice nursing in the Territory of Hawaii. Any such inactive license may be reinstated upon application to and approval by the board and payment of the current renewal fee.

In the past two years when there was no penalty fee, the number of nurses who registered after the expiration date has averaged 275 each year.

Every nurse holding a license registered this year (1959-1960) will be sent a renewal application card to his last known address May 15, 1960. If he does not receive this notice by June 1, he should assume it has gone astray, and he should contact the Board. Right now would be a good time to inform the Board of Nursing if your address has changed since last July. The Board is not responsible if your renewal application is not received. The application card and the registration fee ($2) must be received on or before June 30, 1960, or postmarked midnight June 30.

The nurse who does not expect to practice in Hawaii next year should notify the Board and request inactive status. No fee is required for periods of inactive status. The license may be reinstated upon payment of the fee and filing the renewal application with the Board.

Coming Events

American Nurses' Association Biennial Convention Miami Beach, May 2-6, 1960.

American College of Nurse-Midwifery Sheraton-Park, Washington, D. C., May 6 and 7.

American Psychiatric Association—Session for nurses Atlantic City, May 13.

National Tuberculosis Association—Two nursing sessions will be held in addition to the medical and public health sessions, Los Angeles, May 17 and 18.

Workshops and Education Programs.

University of California Medical Center is offering a number of short courses for graduate nurses in its Continual Nursing Education programs. Fees range from $15.00 to $30.00, and credits toward a degree may be earned. For more complete information, write to Continuing Nursing Education, University of California Medical Center, San Francisco 22.

Affiliation Advisory Committee

Recently Leahi Hospital joined The Queen's Hospital, St. Francis Hospital, Territorial Hospital, and the University of Hawaii in the Affiliation Advisory Committee.

The committee is composed of Miss Virginia Jones, Dean, College of Nursing, University of Hawaii; Miss Eleanor Cranch, psychiatric nursing instructor, University of Hawaii; Sister Evelyn, director of nursing, St. Francis Hospital; Mrs. Hazel Kim, educational director, St. Francis Hospital; Miss Lynne Wigen, director of nursing, The Queen's Hospital; Mrs. Wilhelmina Beckstrom, acting educational director, The Queen's Hospital; Mrs. Rosie Chang, director of nursing, Territorial Hospital; Miss Loretta Schuler, psychiatric nursing education supervisor, Territorial

Hospital; and Mrs. Patience Martelon, director of nursing, Leahi Hospital; and Mrs. Hisako Uyeda, tuberculosis nursing educational director, Leahi Hospital.

The group holds quarterly luncheon meetings, rotating at the participating hospitals and the University, to discuss educational programs and common problems concerning students in their psychiatric and tuberculosis nursing experiences.

Legislative Platform 1960

1. Promote legislation which will provide public funds for research, scholarships, and continued improvement in nursing education and nursing service.

2. Continue to support desirable health legislation affecting community health.

3. Continue to support desirable social legislation including those labor measures which will benefit nurses.

4. Protect and support sound regulatory legislation for nursing practice, and an administrative structure which can implement standards acceptable to the profession.

As adopted by the House of Delegates October 1959.

Clinical and Technical

ANA Action on Infections Problem

The ANA Board at its meeting January 22-28 in New York approved recommendations from two committees designed to assist nurses in meeting the problems of staphylococcal or similar infections.

They were: approval of a statement on the Responsibility of the Professional Nurse in the Prevention and Control of Infections; and adoption of a recommendation urging SNA's to work for extension of state workmen's compensation laws to include compulsory coverage for nurses and inclusion of staphylococcal infection as an occupational hazard.

The Responsibility Statement, formulated by the ANA Special Committee on Infection, points up the nurse's strategic role in any infection control program. It encourages reexamination of basic nursing knowledge and practice in the light of new knowledge and developments. The statement tells what nurses can do to help assure the success of infections control programs.

The statement will be referred to sections for study and will be given the widest possible distribution.

In recommending attention to workmen's compensation laws, the ANA Committee on Economic and General Welfare noted that 24 states do not have compulsory compensation legislation, and many nurses are not covered under laws which do exist.

Current public concern over the problem of infections makes action in the area particularly timely, the committee said.

Many state workmen's compensation laws already include slips, strains, falls, radiation injuries and tuberculosis as hazardous to nurses. Inclusion of staphylococcal infection as an occupational illness under these laws is equally important since a nurse may become ill as a result of exposure, or as a result of infection, may become a "carrier" and be barred from practicing.

Nursing Education and Nursing Service

American Nurses' Foundation Complete First Five Years: Plans to Expand Program

This year marks the Fifth Anniversary of the American Nurses' Foundation. Nurses everywhere can be justly proud of the significant strides that have been made in research in nursing.

From its inception, the American Nurses' Foundation has been concerned with the great changes that have been taking place in nursing care and improvements in nursing practice. And the Foundation has made great progress in fulfilling the purposes for which it was created.

These purposes, in broad terms, are to identify nursing needs and enrich nursing knowledge vital to the proper health care of America's rapidly expanding population and, at the same time, to disseminate, in the public's interest the information gathered by the Foundation to all members of the nursing profession and other interested groups.

Accomplishments

Since the Foundation was created in 1955, almost $300,000 has been expended in research projects sponsored or conducted by the Foundation. Programs supported by the Foundation include studies in the fields of private duty and industrial nursing, nursing personnel and practice in a metropolitan area, nursing service in outpatient departments, nursing the mentally ill, the adjustment of nursing students to a psychiatric affiliation, and practical nursing.

Within the same five-year period projects carried out by the Foundation itself were studies in the field of public health nursing, a program for the regular exchange of information with visiting foreign nurses, and a program to assist Hungarian refugee nurses to prepare for licensure and practice in this country.

In October, 1959, the Foundation received funds to begin a five-year study of family and patient adjustment to the crisis of cardiac disease.

The projects sponsored by the American Nurses' Foundation have been conducted by staffs on which nurses participate with social scientists, clinical psychologists, psychiatrists and other professional personnel. Advisory committees of medical and nursing practitioners and educators stay in close contact with each project, ensuring continuing use of research results as soon as they become available. Progress reports are made and articles are produced to disseminate a wider knowledge and understanding for the total health field.

Both the Foundation and the American Nurses' Association realize that a great deal more work in research remains to be done. The studies themselves have made apparent the serious gaps in research on important areas of nursing. Moreover, experimentation will be needed in order to validate the preliminary research now on hand.

The Expansion Program

Recently the Foundation stated that its future plans have a dual objective: to expand the research grants program in nursing, and to provide means for widespread sharing of research results. The expanded program will continue to promote studies, surveys, research and demonstrations in patient care and nursing practice by emphasizing four areas of research: nursing procedures; the effects on nursing due to changing patterns of patient care; the effects of administrative organization on patient care; and nursing needs of patients, and nursing in different categories of illness.

To carry out these objectives, the American Nurses' Foundation is now undertaking a program to raise funds for its expanded activities. Foundation officials have stated that the financial goal will be announced shortly and will be sought from members of the nursing profession, from corporations and foundations, and from organizations and individuals.

The Moving Frontier

Every nurse must recognize the importance of this program to nursing and to the total health of the nation. Research and the use of research findings is a professional responsibility. Robert K. Merton, Ph.D., Professor of Sociology, Columbia University, has called research the moving frontier of the profession. In "Issues in the Growth of a Profession," American Nurses' Association, New York, 1958, he reminds us that improvement of professional practice depends greatly on the people who devote all or part of their time to methodical investigation.

The program of research in nursing has been our responsibility ever since 1950 when, acting through the House of Delegates, we voted support of the ANA Studies of Nursing Functions, which preceded the formation of the American Nurses' Foundation. Probably no other professional group has ever authorized and financed such an intensive "self-examination" of its own practices!

The need for an effective organization devoted to research in nursing was reaffirmed at the June, 1958 ANA Convention, when the House of Delegates accepted the Supplemental Report of the ANA Committee on Current and Long-Term Goals which states: "With every step the profession takes to encourage the development of research in nursing, it is moving toward full partnership with the other health professions toward improved care for the public."

Clearly, responsibility for the Foundation and its expansion program is ours. We have stated our belief in the need for the program and now we can take an active part in its growth. Some of us take part in research in nursing by conducting studies, interpreting results or utilizing the findings but all of us can participate in the program through our contributions and by telling others about the importance of the Foundation so that they too, will contribute.

As the new decade begins, we must step forward by accepting this challenge and ensuring the success of the forthcoming fund raising campaign by providing the necessary leadership, services, and financial support.

Professional Nurse Traineeship Program

The Short-Term Traineeship Program has been established to enable graduate nurses, now em-

ployed in administrative, supervisory, or teaching positions, to update and improve management and teaching skills most needed to improve the quality of patient care in the institutions and agencies in which they are employed.

This new program is an extension of the Professional Nurse Traineeship Program which was started in 1956 to increase the number of professional nurses qualified for administrative, supervisory, or teaching positions. Approximately 3,800 nurses were awarded traineeships for full-time academic study during the first three years of the program.

The Short-Term Traineeship Program was recommended by the Evaluation Conference on the Professional Nurse Traineeship Program, held August 1958 to study the effectiveness of the traineeships in meeting the needs for nursing leaders.

Short-term traineeships are separate from and do not replace the long-term traineeships for full-time study in colleges and universities.

Any institution, health agency, or other non-profit organization interested in sponsoring short-term training programs may apply for traineeships for nurse enrollees.

To be eligible to apply for traineeship funds, the sponsor must provide a course designed to improve the skills of nurse administrators, supervisors, or teachers, with the focus on the development of a few essential elements of these skills. The courses must be less than a regular university term (i.e., quarter or semester), but not less than five days in length. A course may be taught in a single session or a series of sessions, provided each session of a series is not less than two days in length. The course must be conducted by qualified instructors.

Labor-Management Reporting and Disclosure Act of 1959

The Labor-Management Reporting and Disclosure Act of 1959, commonly known as the Landrum-Griffin Act, was signed by the President and became law on September 14, 1959. One of its requirements is that every organization covered by the Act shall inform its members concerning the provisions of the Act. Because of the Economic Security Programs, under which state nurses associations may represent nurses as employees for the purpose of improving their terms and conditions of employment, the Act does have application for our association. Accordingly, provisions of the Act have been summarized for your information by legal counsel to the ANA. Most of the Provisions became effective on September 14, when the bill became law, or on a specified number of days thereafter. The Act consists of seven titles, plus legislative findings of certain labor abuses and a number of definitions:

TITLE I—BILL OF RIGHTS OF MEMBERS

This title is designed to insure democratic procedures in covered organizations (i.e., organizations which in whole or in part represent or hold themselves ready to represent employees in industries affecting interstate commerce). Every member is given equal rights and privileges to nominate candidates, to vote in elections or referendums, and to attend membership meetings. Every member has the right to meet and assemble freely with other members, to express his views, at meetings or otherwise, and to take proper legal proceedings without reprisals. However, an organization may adopt and enforce reasonable rules as to the responsibility and conduct of its members and may require the exhaustion of remedies within the organization before a member institutes legal or administrative proceedings. Dues and initiation fees may not be increased and assessments may not be levied except by at least a majority vote by secret ballot after reasonable notice, or by at least a majority vote in a referendum conducted by secret ballot, or by at least a majority vote of the delegates at a regular convention, or at a special convention held upon 30 days' written notice to the local organizations (or by interim action by an executive board until the next regular convention). Local organizations are required to forward a copy of each collective bargaining agreement made by such organization to any employee who requests a copy and whose rights as such employee are directly affected by such agreement. Organizations other than local organizations are required to forward a copy to the office of each constituent unit which has members directly affected by such agreement, where the copies shall be available for inspection by any member or by any employee whose rights are affected by such agreement. Members may enforce their rights by action in the District Court of the United States. The Secretary of Labor may also enforce the obligation to furnish or make available collective bargaining agreements.

TITLE II—REPORTING BY ORGANIZATIONS, THEIR OFFICERS AND EMPLOYEES, AND EMPLOYERS

Organizations subject to the law are required to file with the Secretary of Labor an initial report with regard to the name and title of officers, dues and initiation fees, qualifications for membership, levying of assessments, participation in benefit plans, authorization for disbursement of funds, audit of financial transactions, calling of meetings, elections, discipline of officers, agents and members, authorization of bargaining demands, ratification of contracts, auhorization of strikes and issuance of work permits. Many of these items, of course, do not apply to nurses' associations, since they do not engage in such activities. Every organization is also required to file annually with the Secretary of Labor any information required to bring the initial report up to date, together with a financial report with regard to assets, liabilities, receipts, salaries and other disbursements, loans, et cetera. The information must also be made available to its members.

Officers and employees of covered organizations are required to report annually any conflicting interest whchi they had during the preceding fiscal year with respect to any employer whose employees the organization represents or seeks to represent or in any trans-

action with such an employer. They must also report any interest in any business which substantially buys from, sells, leases to or otherwise deals with the organization itself. Payments from an employer or an employer's labor relations consultant must also be reported. Wages and other payments received as a bona fide employee are excluded. No report is required if the officer or employee has not engaged in any of the disapproved transactions or received any of the enumerated benefits.

Employers who pay money to covered organizations or officers or agents therefor (other than bona fide salaries and wages, et cetera), or who have made expenditures for the purpose of influencing their employees' exercise of their right to bargain collectively, must report such payments and expenditures. They must also report agreements with labor relations consultants and similar independent contractors and organizations for such purpose and payments pursuant to such agreements. Such consultants are also required to file reports concerning such agreements, their receipts from employers and their disbursements. There are exceptions with regard to appearances before courts and administrative agencies and the negotiation of labor contracts. Reports are not required from persons who have not engaged in the activities above listed.

Communication with attorneys need not be disclosed. The reports are considered public information and may be inspected by any person. Records of the basic information must be kept for five years. Violation of the title is punishable by a fine of not more than $10,000 or imprisonment for not more than one year. The Secretary of Labor may also bring a civil action for an injunction or other relief.

TITLE III—TRUSTEESHIPS

This title deals with the procedure by which some international labor unions have assumed control over local unions for alleged violation of constitutions and by-laws or other offenses. These provisions, therefore, have little relationship to nurses' associations, where such procedures are not invoked. Furthermore, since state nurses' associations are incorporated, any receivership or dissolution proceeding would ordinarily proceed in accordance with the corporation laws of the particular state.

TITLE IV—ELECTIONS

National organizations must elect their officers at least every five years by secret ballot among the members or at a convention of delegates chosen by secret ballot. Local organizations must elect their officers at least every three years by secret ballot among the members. Both national and local organizations must comply with reasonable requests of candidates to distribute campaign literature to the members at the candidates' expense and to refrain from discrimination with respect to the use of lists of members. Bona fide candidates may inspect a list of members who are subject to collective bargaining agreements requiring membership as a condition of employment.

Officers of intermediate bodies must be elected at least every four years by secret ballot among the members or by representatives elected by secret ballot.

Fifteen days' notice must be given with regard to secret ballot elections. Members whose dues are checked off are immediately eligible to vote or to be a candidate regardless of delay in the transmission of dues. The ballots and other records of secret elections must be preserved for one year.

When officers are chosen by a convention of delegates elected by secret ballot, the credentials of the delegates and all minutes and records of the convention pertaining to the election must be preserved for one year.

The moneys of the organization or of an employer may not be used to promote the candidacy of individuals, but may be used for notices, factual statements of issues not involving candidates, and other expenses of the election. Members of the organization who have exhausted internal remedies or who have invoked such remedies without obtaining a final decision within three months may file a complaint with the Secretary of Labor within one month thereafter. The Secretary shall investigate the complaint and take appropriate civil action if a violation appears to have occurred.

TITLE V—SAFEGUARDS FOR COVERED ORGANIZATIONS

This title states the fiduciary responsibility of the officers and agents of covered organizations. Since state nurses' associations are incorporated, most of these rules already apply to their officers and agents. Provision is made for legal action for violation of fiduciary duty.

Every officer, agent and employee of a covered organization (unless the organization's property and annual financial receipts do not exceed $5,000) who handles funds or other property must be bonded. This rule also applies to officers, agents and employees of a trust in which the organization is interested, such as a pension trust. The bond must be not less than 10 per cent of the funds handled by such person and his predecessors during the preceding fiscal year, but in no case more than $500,000. The bond may not be placed through an agent or broker or with a surety company in which the organization or its officers, agents or representatives are financially interested. The surety company must be one approved by the Secretary of the Treasury as a surety on Federal bonds.

No organization may lend any officer or employee more than $2,000. Communists and felons may not serve as officer, director, business agent or employee of covered organizations or as labor relations consultant to employers or as an officer, director or employee of an employer association. This prohibition does not apply to clerical and custodial employees.

Violations of the above provisions are punishable by criminal penalties, generally by fine of not more than $10,000 or imprisonment for not more than one year, or both.

The Labor-Management Relations Act (Taft-Hartley Act) is amended to include payments by employer associations and labor relations consultants in the prohibition against unlawful payments by employers to employee representatives. The prohibition is also broadened in various other ways.

TITLE VI—MISCELLANEOUS PROVISIONS

This title is a grabbag of provisions and covers such diverse matters as extortionate picketing, discipline of members for exercising rights under the law and use of force or violence to intimidate members for the purpose of interfering with their rights under the law. Appropriate civil or criminal penalties are provided for violations.

TITLE VII—AMENDMENTS TO THE LABOR-MANAGEMENT RELATIONS ACT, 1947

This title contains a number of amendments to the old Wagner Act, as previously amended by the Taft-Hartley Act. State courts and agencies are given juris-

diction over labor disputes which the National Labor Relations Board has declined. The Board is prohibited from narrowing its jurisdiction any further. It is not, however, prohibited from reasserting jurisdiction which it has previously declined. Unless and until it does so, however, states are free to act.

Economic strikers are permitted to vote in any election conducted within twelve months after the commencement of the strike, even though they have been permanently replaced by the employer. The ban against secondary boycotts is widened, and recognition and organizational picketing are regulated and to a large extent prohibited. Since nurses' associations do not engage in such activities, these provisions are of no direct interest to nurses. Special provision is made for the building and construction industry and also for the apparel and clothing industry.

The above summary covers only the principal provisions of the Act. Anyone interested in any of the above topics should consult the full text of the statute. It is known as Public Law 88-257 of the 86th Congress, S. 1555, and may be obtained from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Many of the provisions will be clarified by the United States Department of Labor or by the National Labor Relations Board in the fields of their respective jurisdictions.

District and Section News

Oahu

Mrs. Rosie Kim Chang, director of nursing, Territorial Hospital, was elected President of the Nurses' Association, District of Oahu, at their annual meeting held recently at the St. Francis Hospital.



MRS. CHANG

Mrs. Chang is the wife of Dr. John W. F. Chang. They have one child, John III, a junior at Punahou Academy.

Mrs. Chang is a graduate of The Queen's Hospital School of Nursing, University of Hawaii, and the University of Pittsburgh.

The object of this official association for professional nurses is to maintain and promote the high ethical standards of the nursing profession among its members and to promote their professional and educational advancement and welfare in every proper way. Headquarters are in the Mabel Smyth Memorial Building.

There are over 500 active members in the association, representing all branches of nursing.

* * *

Board of Directors

President: Rosie Chang
1st Vice-President: Phyllis Smith
2d Vice-President: Leona Rubbelke
Secretary: Katherine Kanetoku
Treasurer: Harriet Kuwamoto
Directors: Katsuko Enoki, Esther Higuchi, June Bell, Mabel Davis, Alma Takata, Kazue McLaren, Chairman; Arleen Lance, and Mary Ann DeCosta.

Committee Chairmen and Members

Chairmen in **Bold Face**

Finance: **Harriet Kuwamoto,** Sally Faustino, Flora Ozaki
Program: **Phyllis Smith,** Barbara Burruss, Isabel Medeiros, Leona Rubbelke, Phyllis Yasuda, Colene Wong
Arrangements: **Mabel Davis, Esther Higuchi,** Sister Cabrini, Florence Shibano, Betty Yamane, Sybil Wong
Constitution and Bylaws: **Evelyn Char,** Margaret Bennett, Dorothy Ito, Betty Mitsunaga, Shuku W. Najita
Membership: **Harriet Tonaki,** Irene Kawamura, Norma Winston, Alice Scott, Sister Evelyn, May Lockmiller, Ruth Thurman, Ninfa Maza, Elsie Park, Haruko Obara, Margaret Rodearmel
Nominations: Ine Higa, Betty Kaito, Nancy Sanjume
Legislative: **Evelyn Young,** Maureen Ho, Marjorie Wagner
Economic Security: Hilda Kurz, Olga Frojen, Sister Laurine, Wilhelmina Beckstrom, Edythe Collins, Ethel Edgar, Victoria Loo
Assisting at Fair Booth, 1960: **Helen Frederick,** Alison MacBride, Jerry Mathews, Olga Larson, Belle Broussard, Eleanor De Cristofaro, Edward Chinn, Delpha Peterson
Aloha and Attendance and Transportation: **Mrs. Katsuko Enoki,** Mabel Gordon, Loretta Schuler, Jean Inouye, Olga Larson, Rose Jenkins
Personnel Policies: **Alison MacBride,** Leona Adam, Alice Scott
Special Project: **Alma Takata,** June Bell, Eleanor Apo, Marjorie Moran, Dorothy Hale, Eleanor Fern

Kauai

The Kauai Nurses' Association held its election dinner meeting at Mike's Cafe on January 4, 1960. Elected were Lillian Teshima, first vice-president; Eunice Sun, secretary; and Gladys Ishihara and Patricia McGuire, board members. The terms are for two years.



MISS CHAPMAN

The holdover officers are Edna Chapman, president; Myrna Campbell, second vice-president; Jahne Hupy, treasurer; and Miyoko Ednaco and Nellie Hiyane, board members.

Elvie Manley, as immediate past-president, is automatically a fifth director, according to one of the changes adopted in the Constitution and By-laws.

Annual reports were also given at the meeting.

Mrs. Salley Lee, from Korea, is attending the University of Hawaii under a one-year I.C.A. Public Health Nursing scholarship. She spent one week on Kauai, going with each district nurse on home visits and seeing the Health Department set-up on Kauai. Visits to the scenic areas of the Island were also on her itinerary.

While she was here she showed slides on Korea. It was interesting to note that the landscape there was much the same as is in Hawaii. Included in the slides, were pictures of health centers in several areas of South Korea.

A dinner was given for her at Miss Myrna Campbell's home.

* * *

Josephine Basa, 1956 The Queen's Hospital and 1957-58 University of Hawaii School for PHN nursing graduate, is engaged to Tadashi Najita of Hilo, a 1955 University of Hawaii graduate.

* * *

Dr. and Mrs. Ben Hirano, became the proud parents of twin boys who were born on January 6. Mrs. Hirano is the former Elaine Tanaka.

* * *

Gladys Ishihara will represent the Kauai district members on the INTER-ISLAND NURSES' BULLETIN. She is a graduate of the California Hospital School of Nursing in Los Angeles, 1957, and is now on the staff of Kauai Veterans Memorial Hospital in Waimea.

Maui

President..... Marjorie Okinaka
Vice-president.....Yukiko Higa
Recording Secretary.....Lorraine Masumoto

Board Members: Helen Goshi, Elizabeth McCall, Lorraine Arakaki, Lillian Gill

Committee Chairmen: Finance, Hilda Yatsushiro; Courtesy, Ruth Ikeda; Civil Defense, Marian Wright; Housing, Phyllis Stubbs; Program, Yukiko Higa; Publicity and INTER-ISLAND BULLETIN, June Ikemori; Membership, Margaret Alexander; Constitution and By-laws, Elizabeth McCall; Nursing Information and Professional Advancement, Gloria Foster; Legislative, Grace Lusby; Nominating, Virginia Scheeline, Ann Gillin, and June Ikemori

Hawaii

The annual meeting of the Nurses' Association, County of Hawaii, was held on January 27, 1960, at the Puumaile Nurses' Home at 7 P.M. The Board of Directors meeting preceded the general meeting. Reports from the different committees were given at this time.

The newly elected officers for our association are as follows: President, Elizabeth Stillman, Hilo Memorial Hospital; 2d Vice-President, Irene Clark, Puumaile Hospital; Secretary, Moira Wilson, Hilo Memorial Hospital; Treasurer, Moira Tanaka, Department of Health, Hilo; Board of Directors, Josephine Victor, Hilo Memorial Hospital and Betty Ikeda, Puumaile Hospital. These officers will serve thru 1962. Hold-over officers are Chitose Kanuha, 1st Vice-president, Department of Health, Hilo; Board of Directors, Hideko Kagimoto, and Utako Tao, both from the Hilo Memorial Hospital.

A film on "Human Cell and the Cytotechnologist," was shown to the members during the refreshment hour. It was educational and interesting.

* * *

Miss Mary E. Stanley, one of our most loved members, was made an honorary member of the Nurses' Association, County of Hawaii, on January 27, 1960. She was born, raised, and schooled in Meridan, Connecticut, and in 1922 she graduated from Roosevelt Hospital in New York City. Soon after graduation, she was offered a position as Superintendent of Nurses for the Floating Hospital on Staten Island in New York. Prior to coming to our islands in 1929, she was an instructor in nursing procedures in Alameda, California. Upon her arrival in Hawaii she worked as a private duty nurse at The Queen's Hospital on Oahu. Mary left Queen's and came to Hawaii where she worked as an industrial nurse at Pepeekeo Hospital for five years. She then decided to go on a one-year tour to the Orient, and visited Japan and China. She came back to Hawaii after the year's leave of absence, and resume her private duty nursing. She then went to work at Puumaile Hospital where she was a supervisor of nurses for ten years. Mary retired from active nuring duties in 1951.

Mary Stanley became a member of the Nurses' Association, County of Hawaii in 1930; she has served as President and Treasurer of our association and has served on many different committees. She has worked diligently and untiringly for our Association and was very active in everything she undertook. She always had an answer for every question the members asked concerning the Association; her performance, devotion, and loyalty towards the Association were outstanding. Although Mary is retired from active nursing duties, love and devotion for her profession remain uppermost in her life. Besides being a member of the Nurses' Association, she is also a member of the Hilo Women's Club and does volunteer work for various organizations. She claims she is *makule,* but to all who know Mary, she is far from being *makule,* for she has a full schedule and does many things. Mary has friends all over the country and she enjoys visiting old friends and making new ones. Hawaii is proud and fortunate to call Mary its own and, have her as a member of the Association, thereby making her a true Kamaaina of Hawaii Nei.

Book Reviews

Paediatrics for Nurses, 2d Ed.

By Arthur G. Watkins, 200 pp., $3.75, The Williams & Wilkins Co., 1958.

Written by a Professor of Child Health at the Welsh National School of Medicine, this book is a handy source for a quick general review of pediatrics. Current trends and concepts, especially in the area of childhood diseases, are described concisely. Specific nursing care and therapies, except in a few major illnesses, are purposefully omitted. The chapters on infant diets are especially informative and practical for nurses' use. The British milk and food products mentioned will also add to the reading interest of an American nurse.

In this revised edition two new chapters were added to include the emotional aspect of the child's separation from home and the health and social agencies available in Britain. These topics are discussed briefly also.

GLORIA KUNIOKA, R.N.

The Art, Science and Spirit of Nursing, 2d Ed.

By Alice L. Price, R.N., M.S., 864 pp., $5.50, W. B. Saunders Co., 1959.

As the author states, "The Art, Science and Spirit of Nursing, the newest textbook in the field of Nursing Arts, has been written to familiarize beginning students of nursing with the responsibilities which were unknown to the nurses of previous generations." The emphasis in this text is directed toward principles in nursing rather than the procedure itself because of the varying procedures in different hospitals. Scientific principles are presented so that the student will have a very good knowledge of the principles involved in all nursing procedures and nursing care.

Nursing in the recovery room, intensive care unit, and progressive patient care has been considered in this text due to the newer trends in nursing. The chapter on radiation has been revised to include an understanding of radiation therapy and the nurse's role in the care of patients receiving such therapy.

Each chapter includes a summary of important features, factors to teach the patient, and situation type problems. A topical outline introduces each chapter, giving the student an idea what it will cover, and also is introduced with suggested vocabulary for better understanding of material contained in the text that follows.

This is a very good text book for beginning students in nursing, is well written with larger print than the first edition, has good illustrations throughout the book, and is written simply for students to understand its content and principles. It does not contain any bibliography at the end of the chapters but has a list of it in the teacher's supplement, for use with this text.

GENEDINA BOLOSAN, R.N.

Sociology and Social Problems in Nursing, 3rd Ed.

By Sister Mary Isidore Lennon, R.S.M., R.N., B.S. in Nursing, M.A., M.S.S.W., 483 pp., $5.00, The C. V. Mosby Co., 1959.

The author has endeavored to write on topics which she felt would be of interest to students whose time is too limited for an extensive course in sociology. The book aims to integrate health and social aspects in nursing. The first part of the book covers the fundamentals in sociology, the basic features of society, and aims to familiarize the students with sociological terms. It also describes the nature of organic evolution, the notions of heredity and environment, the social nature of men, the family and civil society.

The second part of the book deals with the nature, causes, and social control of diseases and a description of the agencies available for the solution of these problems.

The instructor will need to supplement her reading greatly in the fundamentals of sociology; however, the main topics are covered and the treatment of the man as a person is excellently done. The bibliographies at the end of each chapter should be of help.

SISTER M. PETRA, O.S.F., R.N.

Medical and Surgical Nursing

By Amy Brown, 850 pp., $8.00, W. B. Saunders Co., 1959.

This book is adequate as a textbook for the medical and surgical specialties and is written briefly and concisely including only the important aspects of each of the subjects. Some areas, such as communicable disease nursing, are covered in more detail than the others. However, generally speaking, the book can be used effectively where the reader wants coverage of important points rather than detail and where a background knowledge in anatomy and certain other fundamentals of medicine and nursing have already been learned.

RUTH LAM, R.N.

Microbiology and Epidemiology. 4th Ed.

By LaVerne Ruth Thompson, R.N., M.S., 581 pp., $6.00, W. B. Saunders Company, New York, 1958.

This text presents the basic principles of microbiology with emphasis upon cellular metabolism. It points up the interaction of host, environment, and pathogen in the causation of infectious diseases. The grouping of infections by methods of transmission rather than by any classification of microorganisms is especially applicable to the development of nursing techniques and concepts. The format is pleasing; the illustrations are good; the "Reading Guide" at the beginning and the "Summary" at the end of each chapter are aids to learning. A valuable nursing text.

C. BURROUGHS, R.N.

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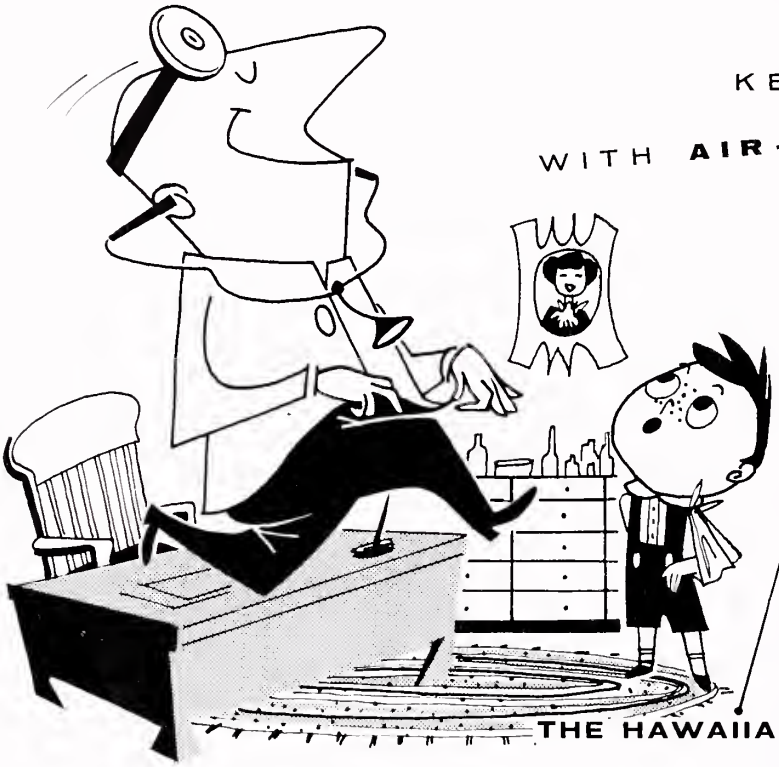
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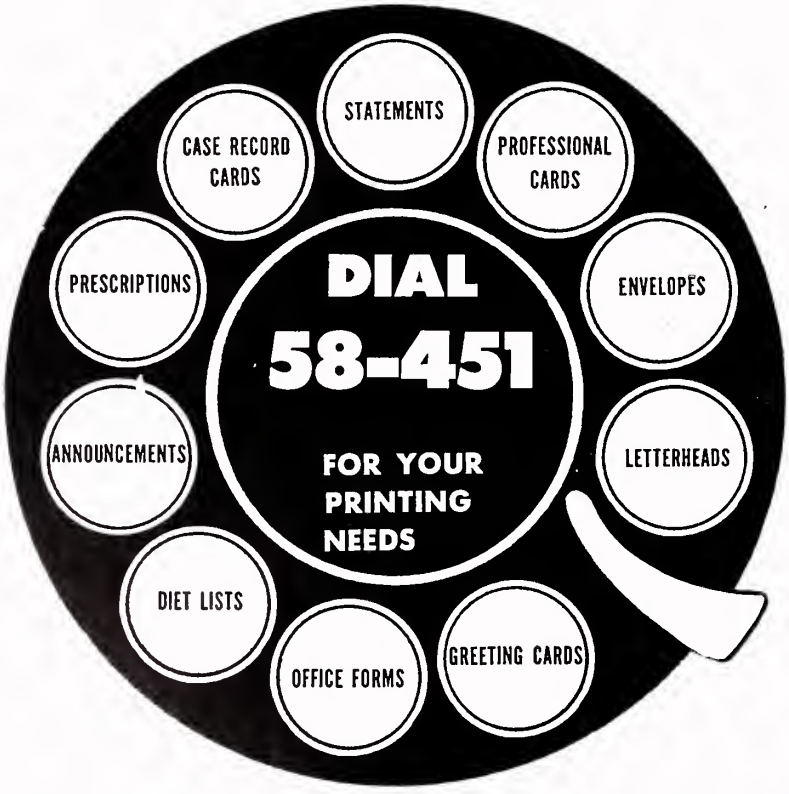
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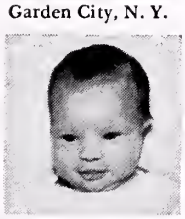
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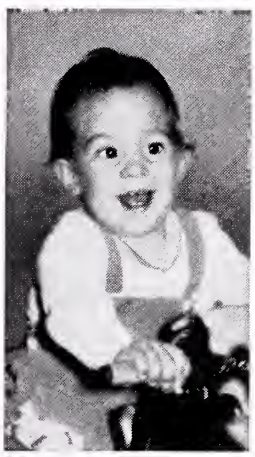
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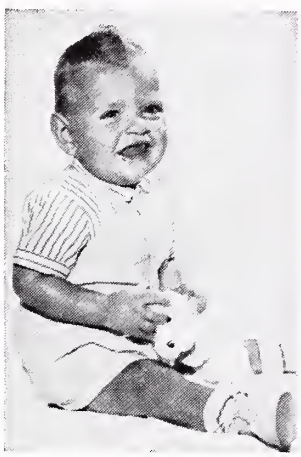
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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

ETHEL NISHIBATA, *Editor* MUN FOOK SHINN, *Associate Editor*

Aloha to Antone Alves Vares

Half-way up Haleakala Crater, at Kula Sanatorium, they staged a luau on January 18 of this year. It was put on by fellow employees to pay tribute to Antone Alves Vares, who retired after giving forty years of devoted service to the hospital. At the same time, the Managing Committee of Kula Sanatorium adopted a resolution "to acknowledge that Mr. Vares had most ably, creditably, and diligently performed all his duties and responsibilities incident to his position."



MR. VARES

Mr. Vares was born in Hamakuapoko, Maui, on March 28, 1895. He joined the staff of Kula Sanatorium in 1918. In 1924 he was made chief medical technologist. His achievements were remarkable when one realizes that he directed as well as performed laboratory tests and otherwise carried out the duties of both the laboratory and x-ray departments. In all this he was assisted only by technologists of the Sanatorium with no help from pathologists or medical technologists from the outside for consultation or exchange of ideas.

He is a living example of pioneering in the laboratory field. His career began at a time when he often had to use primitive methods to achieve his goals. Take the Wasserman tests, for example. To prepare the antigen, Mr. Vares would head for the slaughter house several miles away and beg for an ox heart. He would borrow a meat grinder from the kitchen to grind it and a fan from the dispensary to dry the heartburger. To obtain the hemolysin, he would scour the plantation camps twenty miles away for rabbits. For sheep cells he would simply borrow a lasso from one of the cowboys and head for the pasture. He has since guided and developed the laboratory to one that is as modern as any in the State.

Diagnostic problems were often dumped in his lap and when the chips were down, he always came up with the right answers. In 1938, a young patient from Makawao was admitted to Kula Sanatorium. Shortly afterward he died. A post-mortem examination was performed. Mr. Vares admitted, "I had never heard of bubonic plague, and I had never seen Pasteurella pestis." After examining the smear with the aid of a bacteriology book, he rushed back to the autopsy room and told Dr. Chamberlain that he had found Pasteurella pestis in the specimen. He had! Maui had not had a case of plague for more than forty years, nor has there been another one since.

The career of Antone, as he is called by everyone, spans the pioneering period and the present in the laboratory field in Hawaii. Listening to him and talking with him, one catches the same enthusiasm today which has always been characteristic of him.

His future plans include taking up permanent residence in Dream City, Maui, and making extended visits with his wife to their children in Honolulu and on the Mainland.

MUN FOOK SHINN

Pituitary Gonadotropic Hormones

The FSH test is used to indicate the activity of the anterior pituitary by determining the amount of follicle stimulating hormone excreted in the urine. To date, chromatographic and chemical methods of gonadotropin assay have not proved satisfactory. The method used is a bioassay, utilizing immature female mice or rats. Since the quantities excreted are low, the hormone is concentrated by absorption from an acidified 24-hour specimen on kaolin. It is then released from the kaolin by alkalinizing. The eluate is washed free from estrogens by acetone and further purified[1] by means of a borate extraction buffer and subsequent precipitation with cold 95 per cent ethanol. The precipitated extract is then suspended in water and its activity determined.

The pituitary gonadotropic hormone from the urine stimulates the ovarian follicles in immature white mice. The active state of the follicles causes a precocious secretion of estrin which brings about changes such as a canalization of the vagina,

[1] Albert, A.: Extraction and purification of gonadotropin, J. Clin. Endo & Meta. 18:600-610 (June) 1958.

cornification of the vaginal epithelium, and hypertrophy of the uterus. The presence or absence of uterine hypertrophy after a suitable series of injections of extract is used to determine the hormonal activity of the extract.[2] Immature female mice aged 18 to 21 days (at the beginning of the assay) are injected with 0.5 cc of the extract suspension, or a dilution of it, twice a day for two days and once on the third day, totaling 2.5 cc of suspension injected per mouse. On the fourth day the mice are sacrificed and their uteri stripped, weighed, and compared with the uterine weight of control mice of the same age and size range. An increase of 100 per cent or more over the control uterine weight is taken as a positive result.

For a valid test, the mice must have been raised on Purina Lab Chow, as it has been found that other brands of laboratory animal feed cause an enlargement of the uteri of immature female mice owing to some unidentified substance in the feed.

Until the approach of puberty, follicle stimulating hormone is not found in the urine in appreciable amounts. Normal adult males and adult females before menopause excrete 10 to 50 mouse units per 24 hours. In females the excretion varies periodically with the menstrual cycle, often reaching a peak in the mid-cycle.

The test is of special value in determining whether sexual infantilism or amenorrhea is due to pituitary or ovarian deficiency. When deficiency of estrogen is due to lack of pituitary gonadotropin, the FSH in the urine is usually diminished or absent. On the other hand when hypogonadism is due primarily to absence, atrophy, or disease of the ovaries, the pituitary secretes excessive amounts of FSH owing to the lack of the inhibitory effects of estrogen and the amount in the urine is greatly increased. In most women at menopause there is a marked increase which may begin some years before the menses cease and may persist for many years after. In males, FSH is decreased in sexual infantilism or hypogonadism of pituitary origin. In patients with gonadal aplasia, the FSH is elevated. However without some definite evidence of testicular endocrine deficiency, a negative test does not necessarily indicate a pituitary deficiency.

Reagents:

2N Ammonium Hydroxide: 27.4 ml NH_4OH diluted to 100 ml

Boric Acid Buffer: 500 ml 0.1 N Boric Acid (3.1 gm boric acid—dilute to 500 ml)
59 ml of 0.1 N NaOH
Dilute to 1,000 ml and adjust pH to 8.0

Boric Acid Extraction Buffer:
100 ml Boric Acid Buffer, pH 8.0
100 ml 95% ethyl alcohol
10 gm NaCl

Method:

1. Collect 24-or 48-hour urine, measure volume, adjust pH to 4.5 with glacial acetic acid using Beckman pH Meter.
2. Add 20 gm dry kaolin (Oxford-English, Tamms Industries, Chicago, Illinois) to acidified urine and stir briskly for 5 seconds.
3. Pour into a tall cylinder and allow kaolin to settle overnight.
4. Siphon off urine, being careful not to disturb kaolin. Add 2 liters of tap water acidified to pH 4.5 (about 5 cc glacial acetic acid to 2 liters of water). Stir briskly and allow kaolin to settle overnight.
5. Siphon off wash water. Add 100 ml 2N ammonium hydroxide to kaolin in three portions, washing each time into a flask. Place flask in shaker for 5 minutes, centrifuge contents, save eluate. Add 50 ml water to kaolin, stir up with glass rod, centrifuge, add wash to eluate. Discard kaolin.
6. Adjust eluate (approx. 150 ml) to pH 5.5 with glacial acetic acid.
7. Add 2 volumes of acetone, stir and cool in refrigerator for 2 hours or overnight, until precipitation is complete.
8. Centrifuge, discard supernatant acetone, then add extraction buffer to precipitate—4 ml of buffer for each liter of original urine. Refrigerate overnight.
9. Centrifuge 20 minutes. The supernatant fluid is decanted and saved. Add extraction buffer again to precipitate—4 ml per liter of original urine. Refrigerate overnight.
10. Centrifuge 20 minutes, add supernatant fluid to first extraction.
11. Measure quantity of extraction fluid and add an equal amount of cold 95 per cent ethyl alcohol. The mixture is cooled in refrigerator for one hour and centrifuged for 20 minutes. Discard supernatant.
12. Add 12.5 ml distilled water to precipitate, mix well.

Make dilutions for biologic assay as follows:

5 MU	Original extract (12.5)
10 MU	1:2
25 MU	1:5
50 MU	1:10

If higher than 50 MU make further dilutions of 1:15, 1:20, etc.

13. Use 18 to 21-day-old immature, female mice. Two mice per dilution.
14. Inject 0.5 cc of extract or dilutions of the extract as follows:
    1st day: 0.5 cc morning and afternoon
    2nd day: 0.5 cc morning and afternoon
    3rd day: 0.5 cc morning only
    Thus, each animal receives 2.5 cc of the extract.
15. 24 hours after the last injection (72 hours after the initial injection) the mice are sacrificed.
16. Record the weight of the mice. Examine the vagina and record as patent, semipatent, or closed.
17. At the autopsy dissect out the uterus. Strip the uterus of fat, ovaries, cervix, and blot with filter paper to remove the excess moisture.
18. Weigh the uterus. A positive response is indicated if there is a 100 per cent increase in uterine weight.

Calculation of Dilution:

1 mouse unit (MU) is the amount of pituitary gon-

[2] Obst. & Gynec. Endocrine Laboratory, University of California Hospital (May) 1954.
[3] Modification of Kaolin-Acetone Method of Albert: Staff Meeting of Mayo Clinic, 30:552-555 (Nov. 16) 1955.

adotropin which when given in a series of 5 injections of 0.5 cc each will cause a 100 per cent increase in the uterine weight of a mouse after 72 hours.

Therefore:

$$\frac{12.5 \text{ cc (vol. of extract)}}{2.5 \text{ cc (total inject.)}} = 5 \text{ MU/24 hours.}$$

Precautions:

For best results use Oxford English kaolin from Tamms Industries, Chicago, Illinois, and Purina Lab Chow.

Normals: FSH not found in appreciable amounts until puberty.

Adult males and females—10 to 40 MU per 24 Hr.

Adult females before menopause—excretion varies periodically with menstrual cycle, reaching peak in mid-cycle.

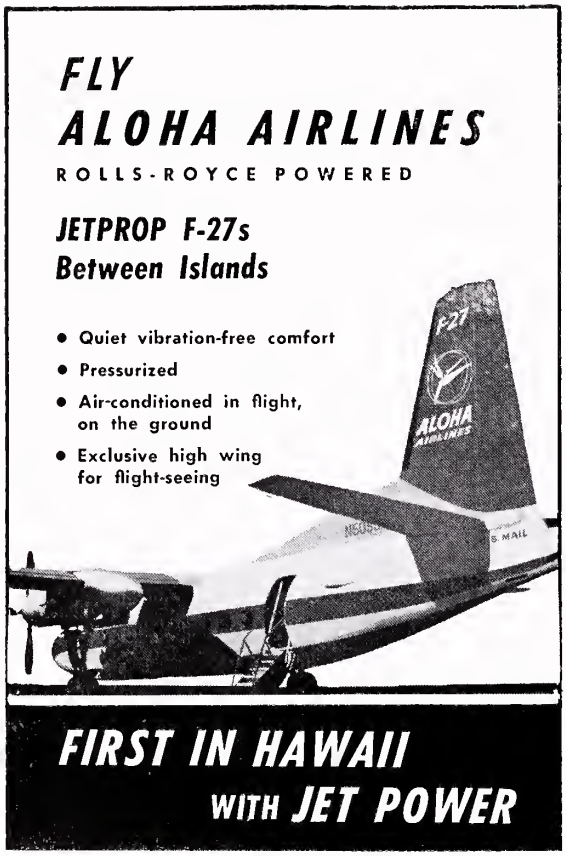
After menopause and also after castration FSH is high due to lack of inhibitory effects of estrogens.

Low FSH: Adult females—shows that estrogen deficiency is due to pituitary deficiency. (Lack of FSH, therefore, no stimulation of follicles to produce estrogen.)

Adult males—decreased in sexual infantilism or hypogonadism of pituitary origin.

High FSH: Adult females—when hypogonadism is due primarily to absence, atrophy, or disease of the ovaries, the pituitary secretes excessive amounts of FSH due to lack of inhibitory effects of estrogen.

Adult males—gonadal aplasia, FSH is elevated.



COUNTY SOCIETY REPORTS

(Continued from page 436)

Following a brief discussion during which Dr. Ando requested that the 1959 budget, approved by the membership at the January meeting, be checked, it was moved, seconded and passed that this whole matter be referred to the next Board of Governors to act on this matter as they saw fit.

The presidential address was then presented by Dr. Richert, followed by the escorting to the rostrum of Dr. Pang, who was duly installed as President of the Society for 1960. After a brief word of acknowledgment from Dr. Pang, there being no new business, the meeting was adjourned at 9:45 P.M.

A. S. HARTWELL, M.D.
Secretary

Kauai

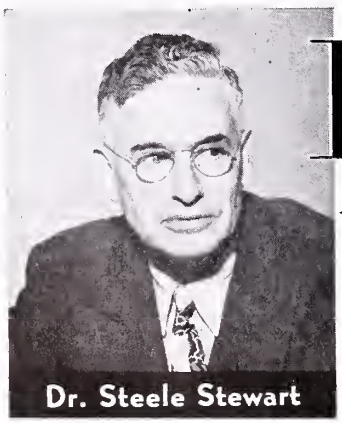
This special meeting was held on August 25, 1959, at 7:40 P.M. in the Wilcox Hospital Library to serve for both the August and September regular meetings, which have been cancelled.

There were no minutes of the July 7th meeting; since it was turned entirely over to a lecture by Dr. Henry Kempe.

Dr. Worth read a letter from Lee McCaslin about the availability of group life insurance if 75% of our members were interested. They were not, and Dr. Worth will so inform the HMA office.

Dr. Worth announced that as requested by our Society, the County Board of Supervisors has appropriated a special fund of $1,200 to pay fees of visiting

(Continued on page 460)



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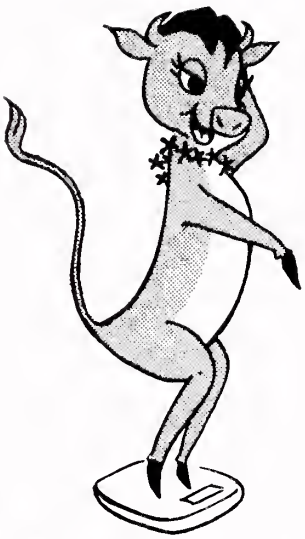
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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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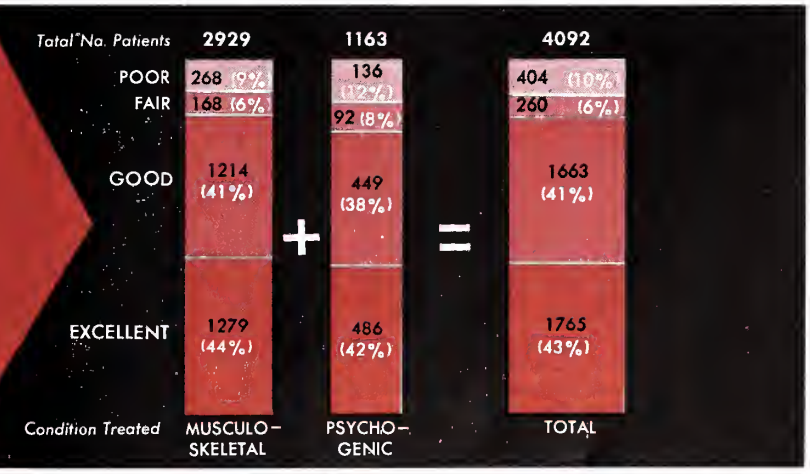
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L. *laxare*, to loosen, as the muscles]

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- FIBROSITIS
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- MYOSITIS
- POSTOPERATIVE MYALGIAS

PSYCHOGENIC
- ANXIETY AND TENSION STATES
- DYSMENORRHEA
- PREMENSTRUAL TENSION
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COUNTY SOCIETY REPORTS

(Continued from page 452)

specialists who see indigent patients here. He was asked to have the County Medical Social Worker inform our consultants of this fund.

Our guest speaker, Mrs. John Devereux, then led us in a stimulating discussion about current legislative issues and the importance of political responsibility and activity on the part of physicians.

Dr. Kim then introduced the question of admitting chronically ill indigent patients to Mahelona Hospital. After considerable discussion, it was suggested that he draw up a set of rules and regulations that would permit the admission of indigents with chronic cardio-respiratory diseases, and that these rules and regulations would then be submitted to the Board of Mahelona Hospital for approval and then be forwarded to the Board of Health.

* * *

The regular monthly meeting was held on October 6, 1959, at 7:37 P.M. in the library of Wilcox Memorial Hospital. Visitors were Doctors Rusch and Garcia.

Dr. Zandee was voted unanimously into membership by all members present.

Dr. Worth and Dr. Boido mentioned that Kauai is the only county where county pensioners get free medical care from government physicians. After considerable discussion, Doctors Fujii, Boido, and Worth were asked to recommend that the Board provide for medical care for these pensioners, and that they do so in such a manner that the pensioner gets free choice of physician.

ROBERT M. WORTH, M.D.
Secretary

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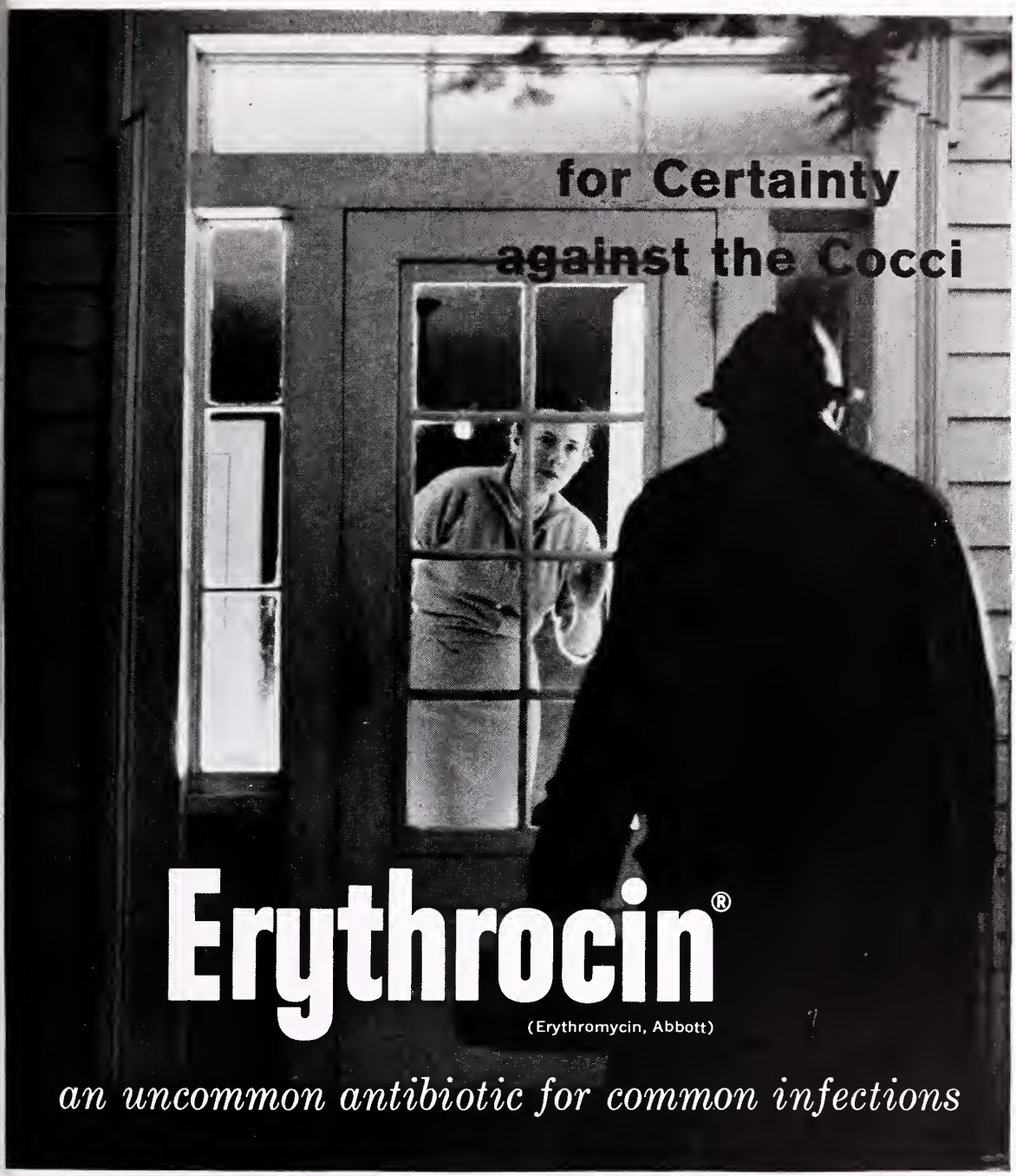
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BOOK REVIEWS

(Continued from page 432)

house officers and to those physicians in practice wh wish to broaden their understanding of breast disease.

GROVER H. BATTEN, M.D.

Roentgenology of the Chest

Edited by Coleman B. Rabin, M.D., F.C.C.P., 484 pp. $19.50, Charles C. Thomas, 1958.

This book, sponsored by the American College o Chest Physicians, is another masterpiece edited by Dr Coleman B. Rabin. In the specialty of chest diseases which is making rapid advances and stirring more an more interest, the editor has gathered clinicians an radiologists who are authorities and who have mad great contributions in their field. The contents show goo organization in that the author was able to correlat roentgenology and clinical chest medicine into one boo with very little repetition of subjects. Included along th contents are basic roentgenology and chest diseases ran ing from pulmonary to esophageal to cardiac. This boo written with the purpose of presenting roentgenology t the roentgenologist from the clinical point of view an to aid the clinician from the roentgenological point o view. It is designed especially for the specialist in disease of the chest but is written also for the rest of the medic profession.

WALLACE W. S. LOUI, M.D.

The Placement of Adoptive Children

By J. Richard Wittenborn, 189 pp., $4.75, Charles Thomas, 1957.

This discussion of practices and points of view rel vant to the adoptive placement of children is based o a research study sponsored jointly by the Department Psychology and the Child Study Center of Yale Uni versity, and it limits itself to two specific questions (1) How accurately and in what respects can the Yal Developmental Examination of infant behavior be em ployed to predict future development of adoptive chil dren? (2) What characteristics of adoptive homes ma be shown to be correlated with characteristics of adop tive children?

In answering these questions the author presents wealth of research data and material, which togeth with his analyses and conclusions make for informativ reading for the physician or social worker who is partic larly interested in the whole problem of child placemen

JOHN T. KOMETANI, M.D.

The Care of the Geriatric Patient

Edited by E. V. Cowdry, Ph.D., Sc.D., 438 pages, $8.00 C. V. Mosby Co., 1958.

Part of this small, compact, well written book wa originally a symposium on the care of the aged, held i Los Angeles in 1955. Since then the scope of the subje matter has been enlarged to cover the physician and th geriatric patient, psychological, medical, mental, and su gical aspects along with chapters devoted to anesthesi drugs, nutrition, dental care, genetics, nursing, hosp talization, proprietary and nonprofit homes, home car rehabilitation, geriatrics training, organization and serv ice for older patients and the final chapter on geriatri around the world.

This treatise is the work of 21 different authors an although there is little continuity of the presentation, f

(Continued on page 464)

Schering

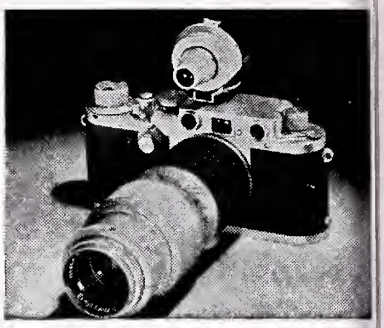
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BOOK REVIEWS

(Continued from page 462)

the physician who treats elderly people or has them in his family this book is of great value and is an excellent addition to our medical library.

R. VARIAN SLOAN, M.D.

Squint and Allied Conditions

By George P. Guibor, M.D., D.D.S., 356 pp., $11.50, Grune & Stratton, 1959.

We are glad that Dr. Guibor has finally set to print the many theories and their practical application concerning the ever-present problem of squint and allied subjects. For 15 years or more he has been collecting data propounding these theories in an attempt to convince ophthalmologists that the treatment of squint is not limited to the mechanical correction by eye surgery.

Reading through the entire book is like being led through an unknown country by the hand of a seasoned traveller. No step is taken without explicit instructions, diagrams, and visual aids. This becomes a little boring at times since we think we know a little about travelling in an unknown country, but must admit that he emphasizes many of the basic rules of travel which have been forgotten.

Dr. Guibor is not a surgical nihilist, even though only 31 pages of a 356-page book is devoted to the surgical aspects.

He does his best to demonstrate that a proper diagnosis combined with medical treatments, which include cycloplegic examinations and use of prisms, bifocals and fusion training, are the "Four Horsemen" controlling the situation.

This is an excellent book for the advanced ophthalmologist (why does he always use the appellation eye doctor?) to keep handy. He needs to read and re-read it, for it is only by intense concentration that this not too-easily read book finally gives up its treasure to the reader.

THOMAS W. COWAN, M.D.

Surgery of the Colon

By E. S. R. Hughes, M.D., M.S. (Melb.), F.R.C.S. (Eng.), F.R.A.C.S., 415 pp., $12.50, The William & Wilkins Co., 1959.

As the title implies, this book deals with diseases of the colon requiring surgical attention. This subject material is well covered by the author with excellent references and illustrations. This book does not delve into operative technics but is an attempt to describe the salient features of the various colonic diseases. In doing so, the author draws on his personal experience, study of the disease, as well as the views of other investigators. Admittedly, the contents of the book can be obtained from various textbooks and journals, but the author has succeeded in assimilating and condensing the pertinent factors of each disease in a single volume in a very presentable and readable manner. This book should prove to be an excellent addition to the library of any surgeon dealing with colonic diseases.

RICHARD OMURA, M.D.

★Manual of Radiation Therapy

By K. Wilhelm Stenstrom, Ph.D., 94 pp., $4.50, Charles C. Thomas, 1957.

This little volume of 90 pages is a surprisingly comprehensive, compact presentation of the radiotherapy

(Continued on page 470)

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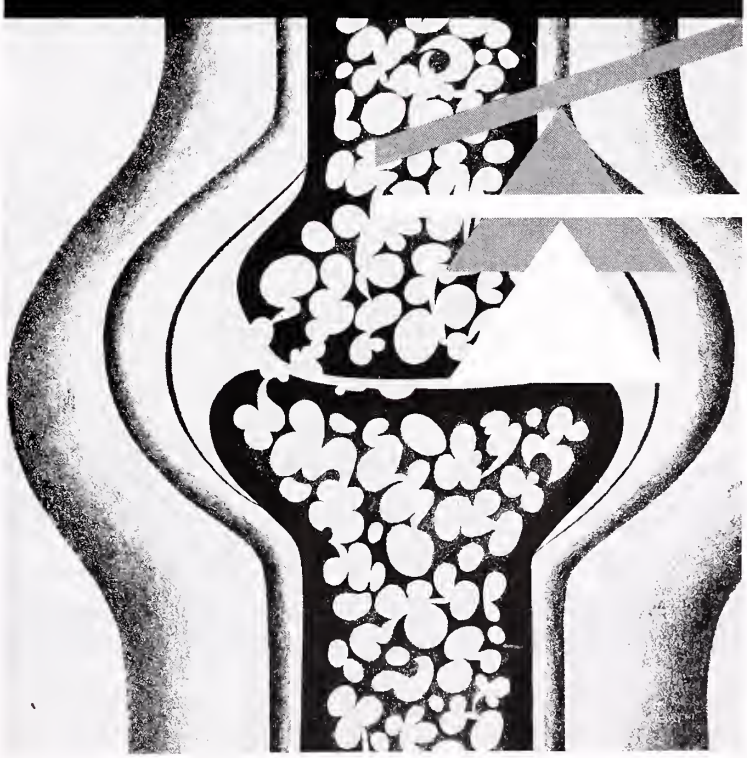
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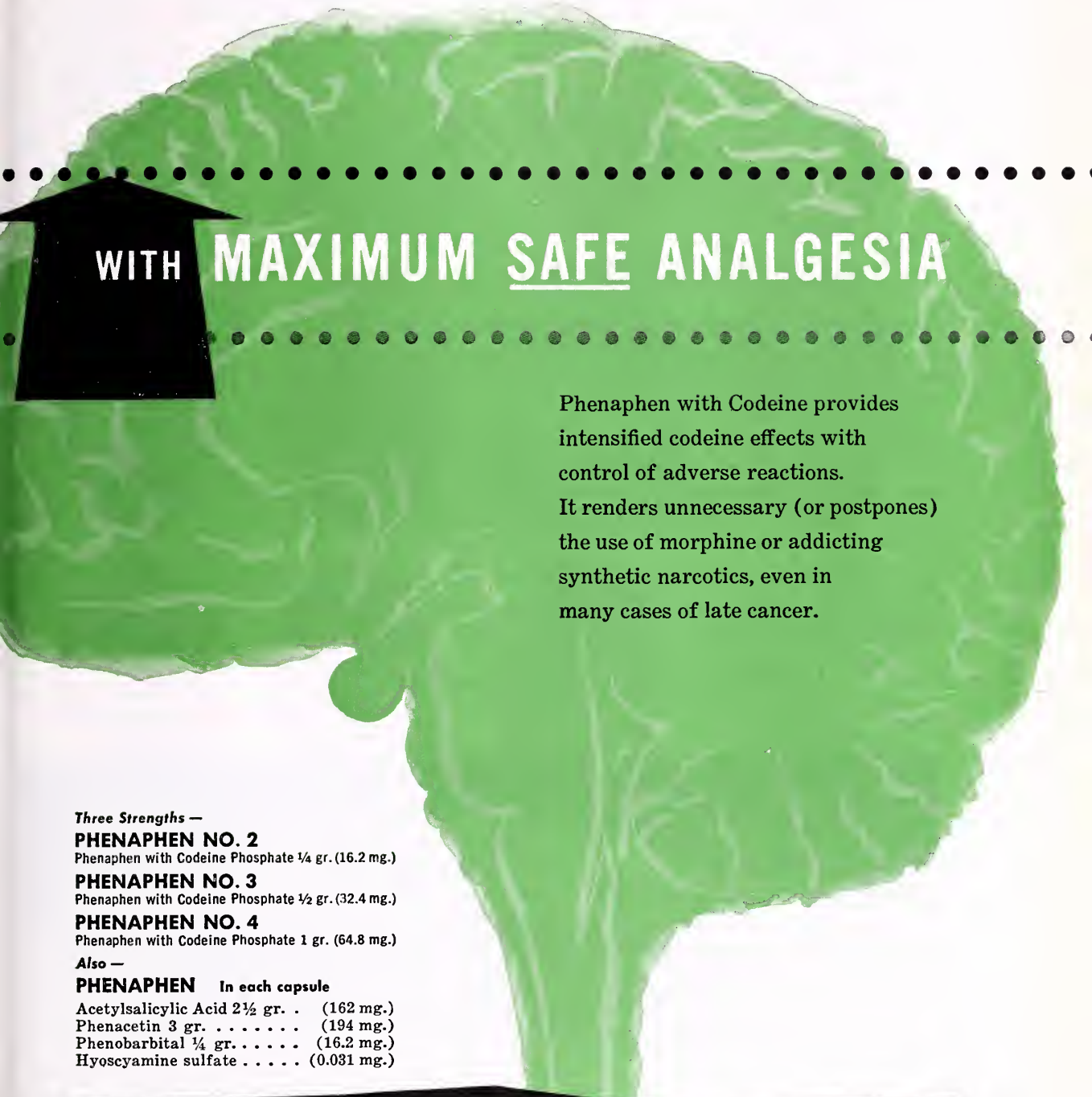
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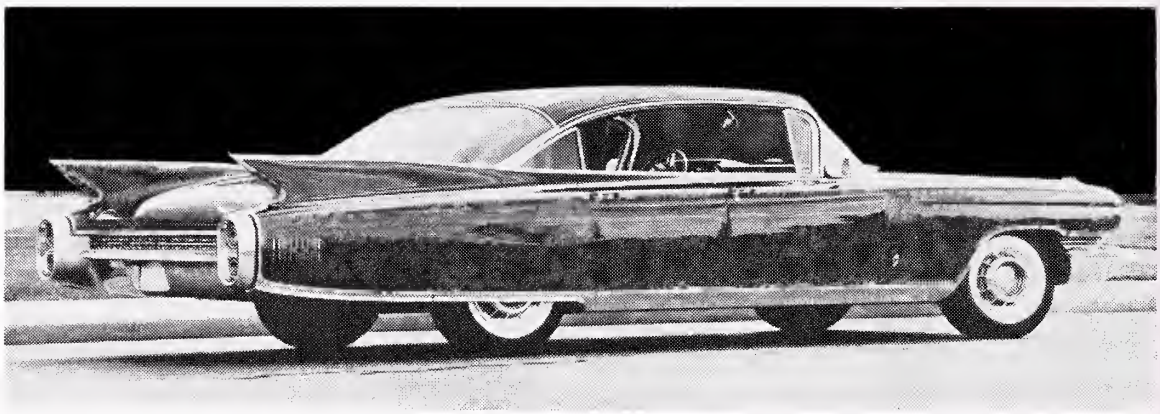


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BOOK REVIEWS

(Continued from page 464)

methods developed over a long stretch of years at the University of Minnesota Medical School. Basic physical and biological aspects are included. The entire range of malignant and nonmalignant diseases generally treated by radiation therapy are included. There is also a brief reference to the use of isotopes. A useful table on lead sheet thicknesses for patient protection against various radiation energies is included. The book achieves the purpose of furnishing a modern guide to the student or beginning radiologist but should be of comparative value to any radiologist doing therapy since it does present the formulated experience of one large medical center.

EDGAR S. CHILDS, M.D.

Psychosomatic Ophthalmology

By T. F. Schlaegel, Jr., M.D., and Millard Hoyt, M.D., 523 pp., $11.00, The Williams & Wilkins Company, 1957.

Anxiety, according to Webster, is a painful uneasiness of mind, respecting and impending an anticipated ill. In *Psychosomatic Ophthalmology,* the author calls attention to the roles of anxiety and other emotional factors in the etiology of noninfectious eye diseases. The concepts of equating injuries to the cornea with defloration of the hymen, recurrent erosions of the cornea with frustrated sexual relations, and presbyopia with emotional insecurity and sexual tension, may startle the more conservative clinical ophthalmologists. Yet, if we agree with Alexis Carrel, that the premature wearing out of modern man is due to worry, lack of economic security, overwork, and excesses of all sorts, then many of the author's hypotheses become more plausible.

The book gives an excellent account of approved psychotherapeutic methods in handling patients who are about to undergo eye surgery and those who are blind.

WILLIAM JOHN HOLMES, M.D.

Progress in Cardiovascular Diseases

By Charles Friedberg, M.D., 108 pp., $3.00. Grune & Stratton, 1958.

This is a new quarterly publication in cardiovascular diseases intended not only for the specialist in cardiovascular diseases but also for the general physician. A review of the first four symposia reveals an excellent choice of subjects that are of widespread interest. The book endeavors to bring to the reader the intensive studies in the rapidly advancing fields of cardiology and cardiac surgery. The articles, written by prominent men in their specialty, provide a variety of experience in experimental, laboratory, and clinical studies. The subjects are concise and clear with simple illustrations and a fine bibliography. This journal should be in every library and be available for all in medical and surgical cardiovascular training.

WALLACE W. S. LOUI, M.D.

Clinical Cardiopulmonary Physiology

Editor-in-Chief: Burgess L. Gordon, M.D., 759 pp., $15.75, Grune & Stratton, 1957.

In the field of chest disease which is becoming more complex and men who have spent their entire life in the study and investigation of a small part of this area, the author has these outstanding contributors write on their respective subjects. Dr. Gordon has done a fine job in correlating so complex a subject as clinical cardiopul-

(Continued on page 474)

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1. H.Swartz, Current Therapeutic Research, 1, Nov.1959.

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BOOK REVIEWS

(Continued from page 470)

monary pathophysiology into one book. In so rapid and advancing field, this volume serves a comprehensive review of the existing knowledge up to 1957. To the researchers, this book may be slightly outdated but to the clinicians it is more than adequate. Like all multi-authored books there is repetition in some phases that is unavoidable. The chapters in basic cardiopulmonary cardiology are noted, the values obtained and how to interpret the data gathered are shown. This book is excellent for those interested in fundamental as well as clinical cardiopulmonary physiopathology.

WALLACE W. S. LOUI, M.D.

★ Rehabilitation in Industry

Edited by Donald A. Covalt, M.D., 154 pp., $6.00, Grune & Stratton, 1958.

This little book presents a collection of concise and most useful papers in subjects which the generalist is certain to appreciate. The preventive medicine aspects of rehabilitation are clearly set forth. The generalist who reads this material and practices it is the one who cannot only reduce the disabilities that follow injury but derive greater satisfaction in dealing with some of his most puzzling and difficult cases.

The only criticism of this little book is that the title may lead the generalist away from purchasing it. The subject matter is without question of interest to physicians in industrial medicine but it is as close to the interests of the generalist as the common cold or the stomach ache.

R. FREDERICK SHEPARD, M.D.

Sorok—Let Sovetskovo Zdravookhraneniya

(Forty Years of Soviet Health Agencies), Govt. Printin, Establishment for Medical Literature, Moscow, 1957

This is a complete history of development, listing, an description of all sorts of medical and ancillary facilitie in the Soviet Union. It includes minute data on hospital and sanatoria, National Public Health Service, prophy lactic health clinics, psychiatric facilities, mobile healt units, prenatal clinics, maternal health programs, nurs eries for newborn, nurseries for children of workin parents, military medicine, medical schools, schools o nursing, medical libraries, industrial medicine, etc.

H. E. BOWLES, M.D.

Also Received

British Medical Bulletin, September, 1959

C. H. Andrews, Scientific Editor, pp. 175-250, The Med ical Department of the British Council, 1959.

Current virus research which includes reports on ade noviruses, measles, varicella, and trachoma is presente in this periodical for the first time since 1953.

The Surgical Clinics of North America, Vol. 39, No. 5

Robert Turell, M.D., Guest Editor, pp. 1149-1465, W. B Saunders Co., October, 1959.

An inventory of the recent advances and retreats i the physiopathology and surgical treatment of lesions o the alimentary tract.

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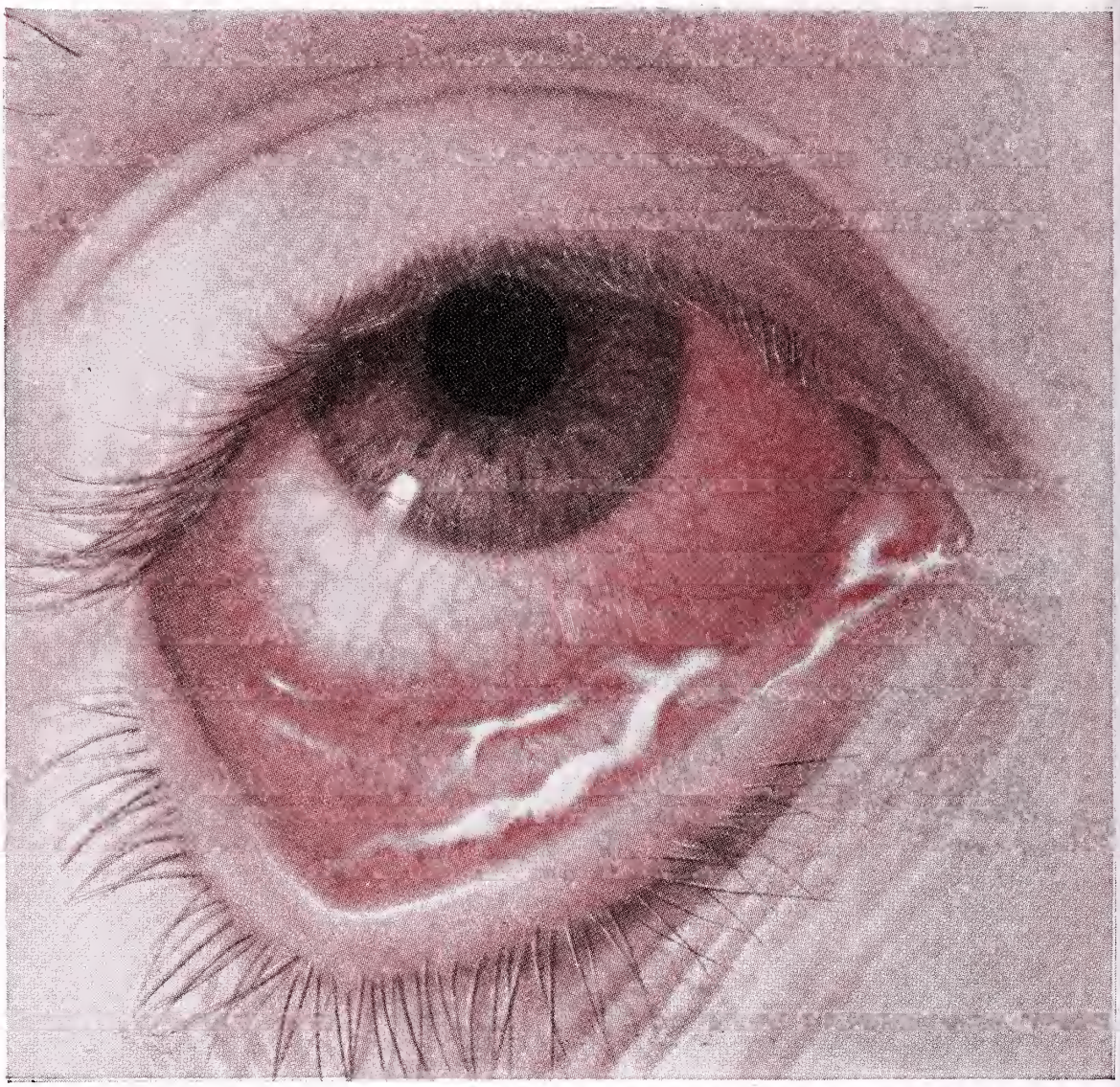
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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1. Lippmann, O.: Arch. Ophth. 57:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. 46:740, November 1958.

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1. Perkins, J. L.: Kansas State M. J. (to be published).

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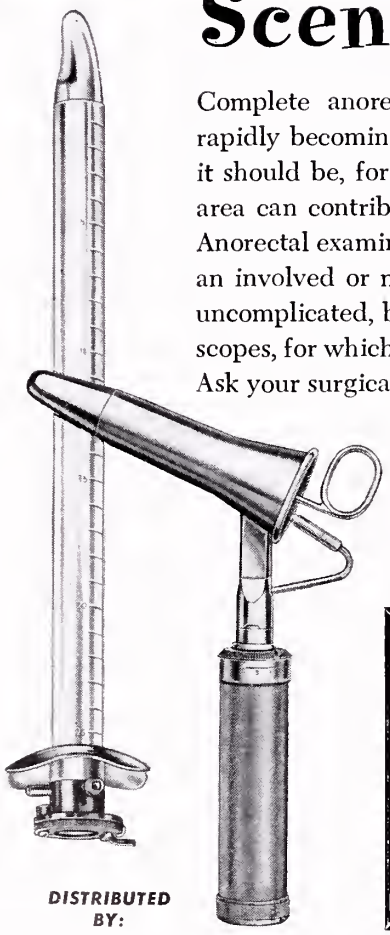
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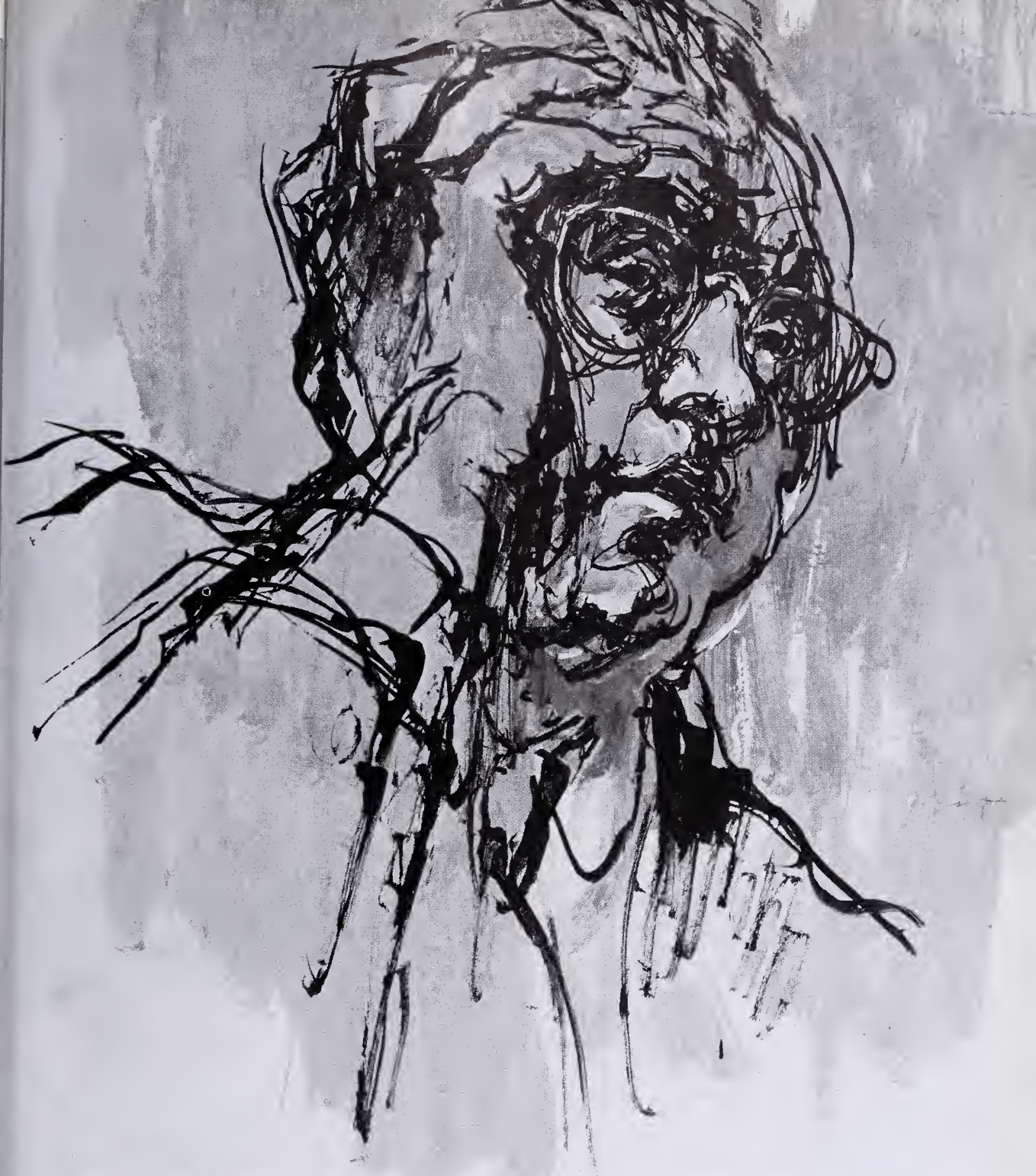
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REFERENCES: 1. Campbell, M. F.: Principles of Urology, Philadelphia, W. B. Saunders Co., 1957. 2. Colby, F. H.: Essential Urology, Baltimore, The Williams & Wilkins Co., 1953.

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Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."*

DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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HAWAII MEDICAL JOURNAL

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HAWAII TECHNOLOGISTS' BULLETIN

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Correspondence

Complaint Department

UNIVERSITY OF HAWAII
HONOLULU 14, HAWAII

7 January 1960

Hawaii Medical Association
510 South Beretania
Honolulu, Hawaii

Gentlemen:

Regarding the article from the Honolulu Advertiser, we are an excessively alarmed people," but not because of "cranberries, charcoal and chickens." It is because, under existing social conditions, we dread the possibility of becoming ill and being drained of every penny of earnings and of even having to borrow for

doctor bills
hospital bills
nursing care
medicines, which are priced beyond reach.

A large group of us here have turned to the Kaiser Medical plan and find satisfaction in it, for it relieves us of that ever-present dread of being financially ruined in the event of having surgery or suffering a prolonged illness.

When are A.M.A and the rest of the medical associations going to do something to alleviate a condition that should have been remedied long before this? What are you waiting for?

This isn't a "crank" letter. It's just an expression of fear, a feeling of helplessness, and anger engendered by having to face medical charges beyond all bounds of reasonableness for the average American citizen.

And so I remain,

An angry, average American citizen.

An instance of some of the things we "average citizens" encounter.

On the Mainland this summer I was the victim (almost) of what I consider an unethical practice. A physician gave me a prescription for an ointment to relieve a skin irritation. I took it to a pharmacy and was able to observe, in a mirror, that the pharmacist tore the label from a tube of ointment, re-labeled it with typed name and directions for use, and asked a fantastic price for it. I did NOT accept the "doctored" medicine. Having remembered the name of the ointment, as written on the prescription (the legible writing was probably a mistake on the doctor's part), I went to another pharmacy and paid the regular price for the tube.

Is this an indication that doctors get a rake-off from Pharmacists?

copy to: A.M.A.

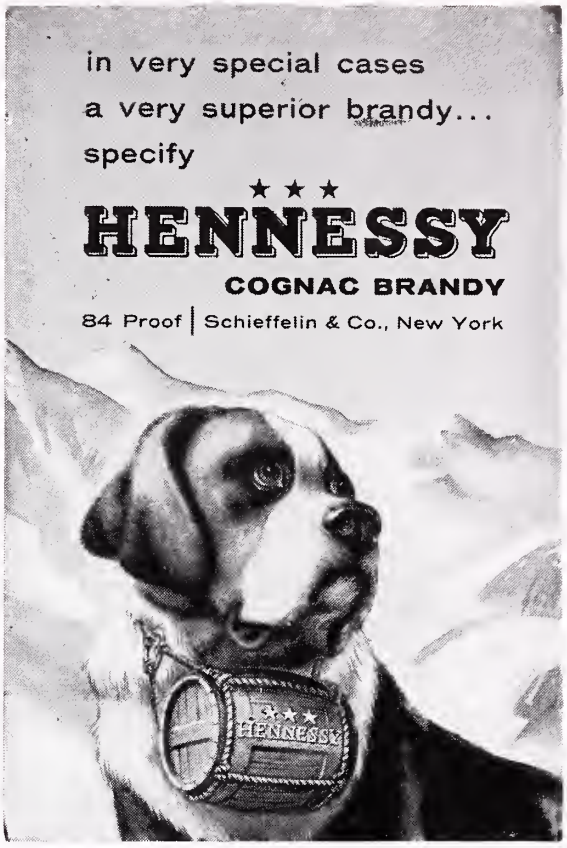
Dread of financial ruin, whether because of the need for surgery or the occurrence of a prolonged illness, or because of other catastrophes, is indeed an unpleasant feeling, and a citizen would have a right to be angry if nothing had been done to enable him to get protection against it.

Something has been done. Nearly 280,000 citizens in Hawaii have availed themselves of commercial insurance to protect themselves against such disasters, and nearly 180,000 have signed up with the medical-society-sponsored service type of insurance plan, the H.M.S.A., which has been growing steadily since it was established here by teachers, social workers and the Honolulu County Medical Society some 25 years ago.

So the answer to the first question is that we're waiting for nothing; we have already done what he demands that we do.

The answer to his second question is "No." The experience described is not an indication that doctors get a rake-off from pharmacists. The implication that this practice is widespread is improper and unfair. Most doctors are honest and ethical and would not lend themselves to such a practice.

It was the second pharmacist, not the first, who misbehaved—by dispensing medication without a physician's authorization.



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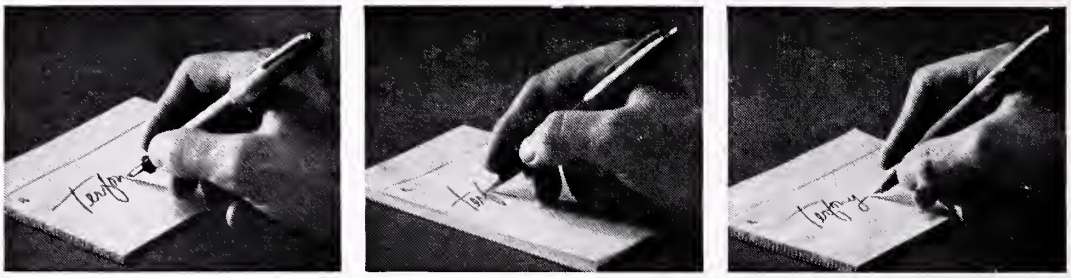
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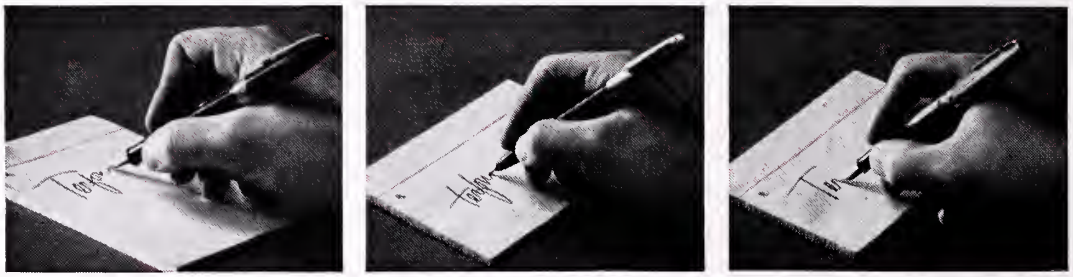
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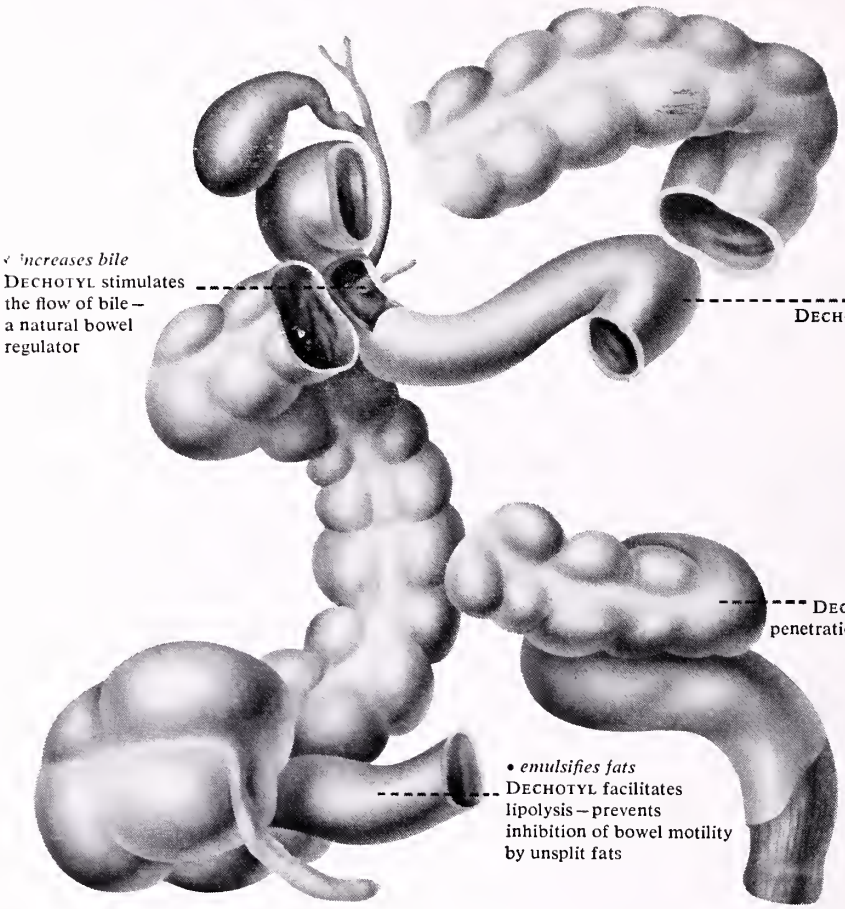
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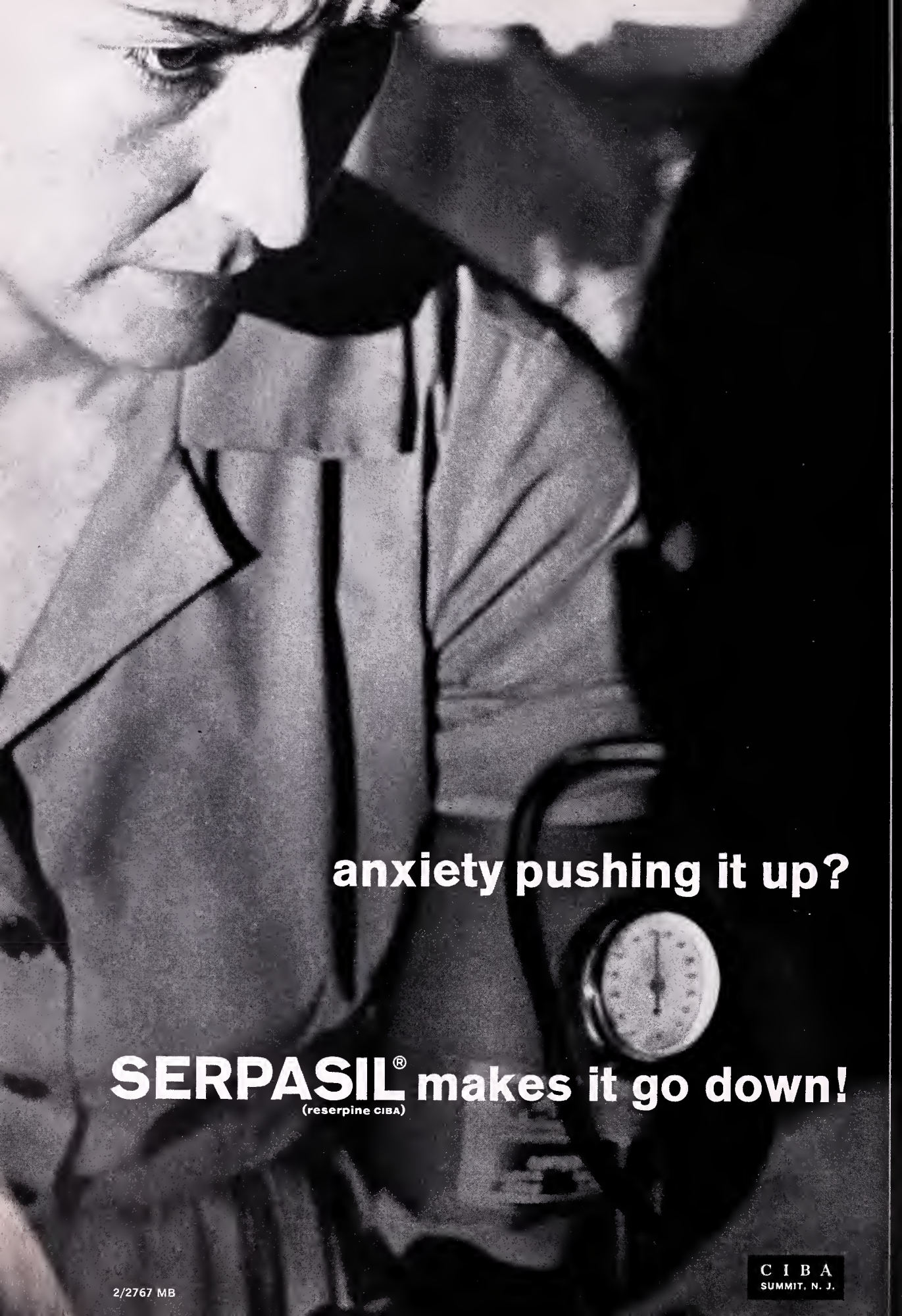
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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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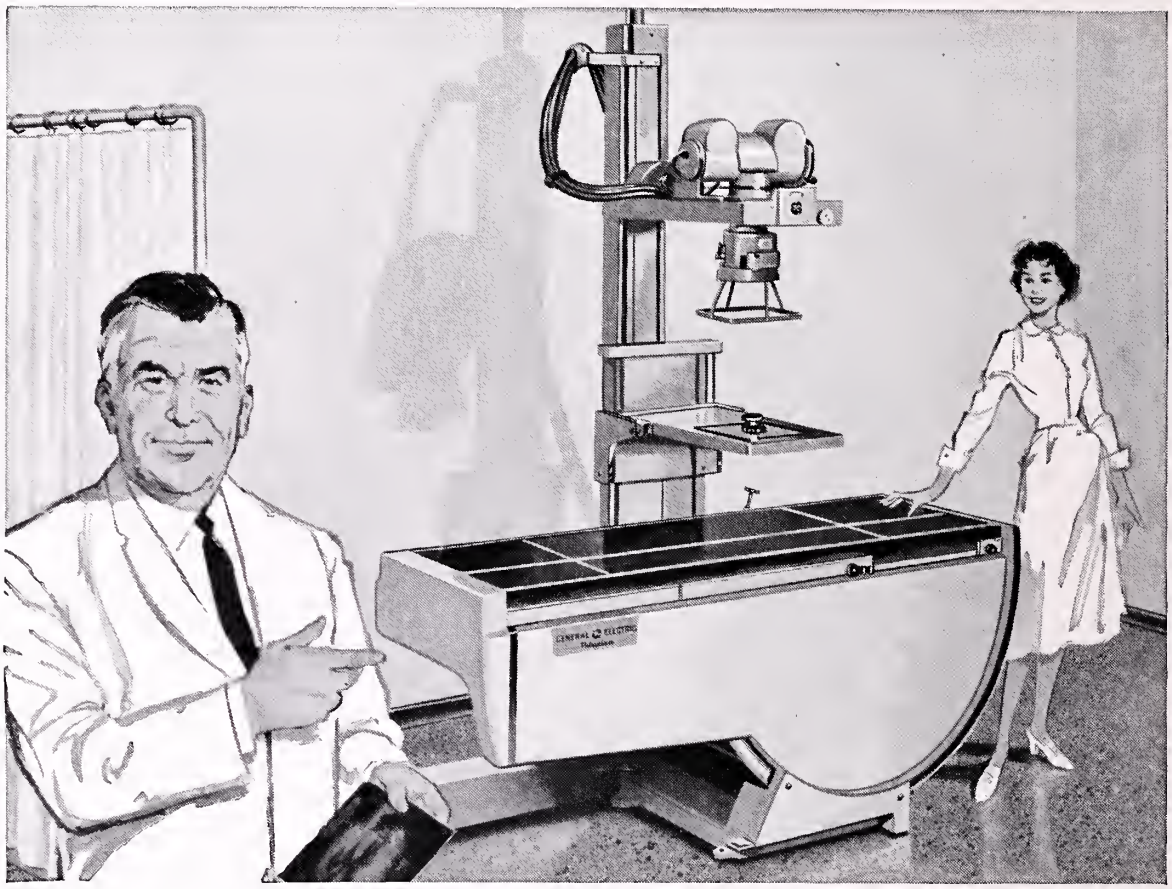
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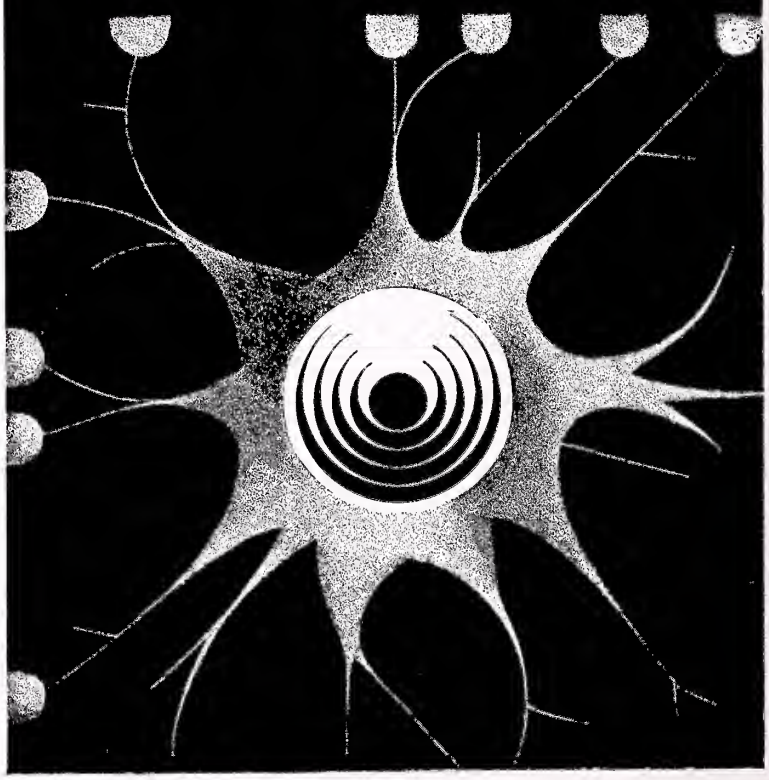
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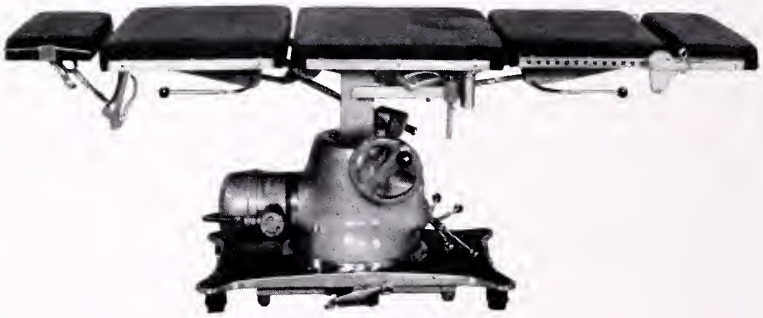


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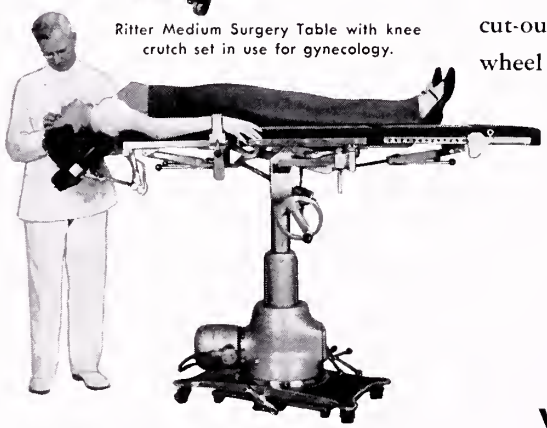
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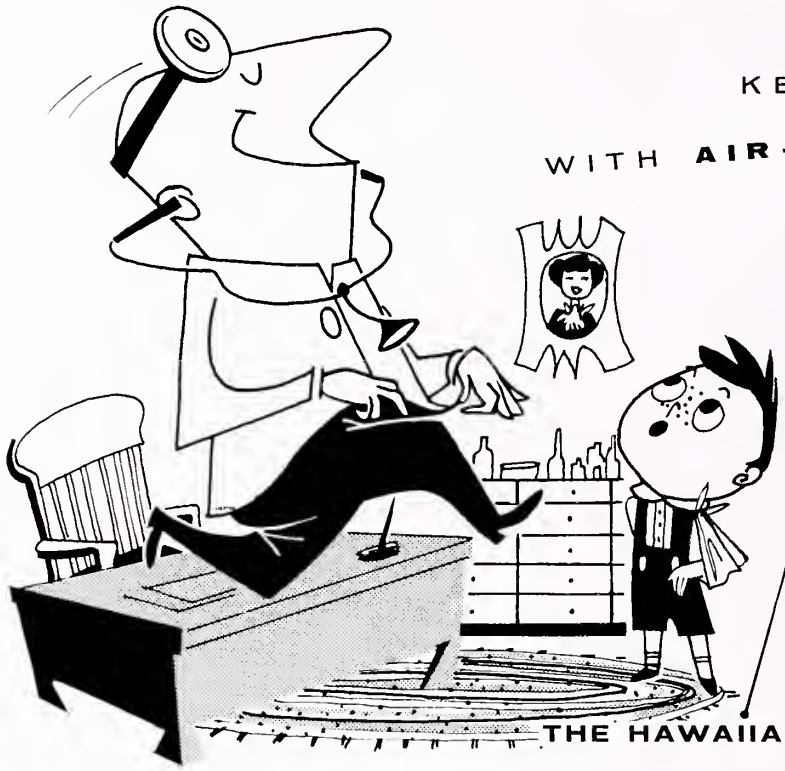
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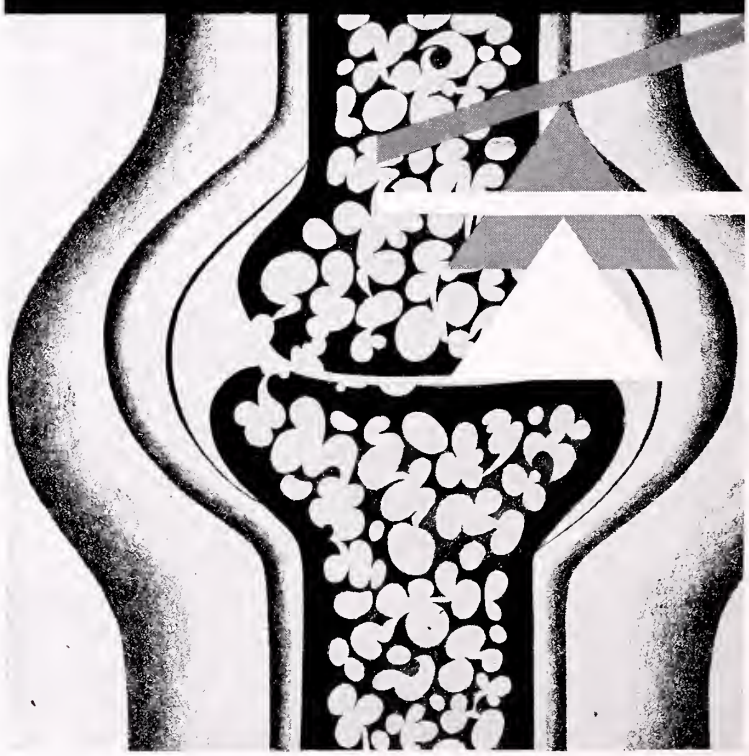
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Lysaught, J. N., and Cleaver, W.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959 (published Nov., 1959)

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1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

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INH treatment of 5 student nurses whose PPD reactions became positive seems so far to have prevented TB in them

Control of Tuberculosis In General Hospital Personnel

Value of Repeated Tuberculin Tests and Isoniazid Treatment of Converters

HOMER M. IZUMI, M.D., Honolulu

THE HAZARD of tuberculosis among persons who care for tuberculous patients has long been a serious problem. Particularly is this true in the general hospital where previously undiagnosed tuberculous cases are admitted and hospital personnel are unintentionally exposed. Nurses, interns, and resident physicians, by reason of their intimate care of the sick patient, are notably potential contacts. It is not surprising, therefore, that the incidence of tuberculosis in nurses, interns, and resident physicians should be higher in general hospitals than in tuberculosis institutions.



Bauer

DR. IZUMI

Despite such protective measures as x-raying hospital admittances, tuberculin testing and x-raying of personnel, and careful follow-up of those showing tuberculin conversion, the incidence of development of active tuberculosis, particularly in the nursing and physician group, stimulated interest in improving this phase of the personnel health program at St. Francis Hospital. This report covers a period of three and one-half years of this program in which recent tuberculin converters have been treated with isoniazid (INH). A search of medical literature reveals a lack of similar reports in such a group.

The Problem

St. Francis Hospital in Honolulu, Hawaii, is a general hospital of 222 adult beds and 28 bassinets, with an admission rate of approximately 10,500 inpatients a year. The St. Francis Hospital School of Nursing in the ten-year period 1946-1956 has admitted 537 student nurses. Approximately ten per cent have shown a conversion of previously negative to positive Mantoux tests, and seven cases of clinical active tuberculosis have occurred during or shortly after completion of their three-year curriculum. In addition, two cases have developed in the intern-resident group, and three cases in other hospital personnel.

While a few of these cases were actually reactivation of pre-existing disease, notably in the intern-resident and other hospital personnel group, the remaining majority were in student nurses who

Acknowledgment is made to the Oahu Tuberculosis and Health Association for a research grant in partial support of this program.
Received for publication October 26, 1959.

had no histories or clinical findings of disease prior to hospital affiliation. Workmen's compensation insurance awards, made to seven cases, are only a rough index of the extent of the problem. Resultant interruption of professional study, career disruption, the added burden of insurance costs, and the expense in hospitalization and treatment of these cases are important tangible factors of these experiences. Aside from the loss in presently scarce professional-level personnel, the psychological and socio-economic experiences of the individual patient are intangible but of real importance. Taken altogether, these experiences indicated our past efforts might be improved, particularly with our present knowledge of the disease and the availability of the new anti-tuberculous drugs.

The Study

In 1955, under the auspices of the hospital administration, a Committee on Personnel Health was formed. While its purpose concerned all phases of personnel health, its primary initial function was to improve the anti-tuberculosis program, particularly that for the student nurse group. Advisory assistance in this function was provided by Drs. Hastings Walker and Michael Brodsky of Leahi Hospital, and Dr. Robert Marks of the Tuberculosis Bureau of the Hawaii Department of Health. A more intensive and thorough anti-tuberculosis program was developed and is being carried out.

Briefly, this program was based on the new concept that the conversion from a negative to a definite positive tuberculin test is the earliest manifestation of the disease. It has long been known that in this early stage the tuberculous infection is microscopic and highly vascular, thus being amenable to a potent anti-tuberculous drug carried in the bloodstream. The effectiveness of treatment with such a drug in this stage of the disease has been favorably reported both in animals and humans.

INH (isoniazid) alone or in combination with other drugs has been used in these experiences. Furthermore, INH has been so nearly universally used in the treatment of active tuberculous cases that we can be sure of its effectiveness. It is practically nontoxic, easily taken by mouth in a tablet form, and ridiculously cheap judged by our present-day cost of medicines. Thus the treatment of this disease in its earliest manifestation, using a drug proved for its nontoxic, yet anti-tuberculous effectiveness, seemed warranted in certain selected ages and groups where past experience had shown a higher incidence toward subsequent development of active tuberculosis. It was the opinion of this committee that hospital personnel, particularly nurses and physicians in training at St. Francis, were within this category.

TABLE 1.—*Summary of Test Results.*

Total individuals tested	1,218
Total PPD tests given	5,488
0.0002 mgm strength	4,085
0.005 mgm strength	1,403
Number of individuals initially positive to 0.0002 mgm	220
Number of individuals initially positive to 0.005 mgm	131
Number of individuals converting to 0.0002 mgm	7

Certain features of this problem, some unique to Hawaii, should be mentioned:

(1) Almost all the student nurses are island born. They are representative of a stable, relatively nonmigrant population which over the years has had better than average screening in programs in tuberculosis detection.

(2) The results of these programs are reflected in the vast majority of students entering the nursing school as tuberculin negative reactors. All of these students were at least 17 years of age upon entering the School of Nursing.

(3) This group, which by past experience posed a challenge in our anti-tuberculosis program, presented an ideal opportunity for use of the tuberculin test as a key detector, since close supervision was possible over the three-year training period. Treatment of the recent tuberculin converter, using INH, without disruption of studies or jeopardizing the compensable status of the individual, had the approval and cooperation of the Bureau of Workmen's Compensation and the hospital's insurance carrier.

(4) Since the majority of these nurses upon graduation will serve hospitals in Hawaii, subsequent follow-up will present few difficulties. In contrast, other hospital personnel, graduate nurses, interns and residents, due to shorter periods of affiliation, were generally less amenable to these features.

(5) The program had teaching value. On-the-spot demonstrations and lectures to participating nurses and house physicians aided their proficiency in the technique and evaluation of the tuberculin test.

(6) This undertaking assumed the proportions of a pilot study which may provide the basis of an anti-tuberculosis program in other general hospitals.

Results

From the beginning of this study three and a half years ago, this program has involved 396 student nurses, 281 graduate nurses, 497 other employees, 34 house doctors, and 10 nuns, comprising 1,218 persons. A total of 5,488 tuberculin tests were administered to these participants, as summarized in Table 1. The test dose of 0.0002 mgm PPD (10 TU) intradermally was adopted as the routine test inasmuch as it had been the standard dose employed by the Department of Health and others engaged in community-wide surveys in Hawaii. The test material was freshly prepared and supplied at two-week intervals through the Tuberculosis Bureau of the Department of Health.

TABLE 2.—*Summary of Hospital Groups Tested.*

	STUDENT NURSES	GRADUATE NURSES	OTHER EMPLOYEES	DOCTORS	NUNS	TOTAL
Number Individuals Tested	396	281	497	34	10	1,218
No. positive to 0.0002 mg	16	52	117	29	6	220
No. positive to 0.005 mg	10	25	88	8	0	131
No. negative to both 0.0002 & 0.005 mg	356	143	150	4	0	653
No. conversion negative to positive	5	0	1	1	0	7
No. converters treated with INH	5	0	1	1	0	7
Total tests 0.0002 mg given	1,515	1,132	1,367	48	23	4,085
0.005 mg	703	329	361	10	0	1,403
Total tests both dilutions	2,218	1,461	1,728	58	23	5,488

Negative reactors to the 0.0002 mgm PPD were retested with 0.005 mgm (25 TU) dose; 1,403 such tests were administered before it was discontinued as an unsatisfactory screening dose because of the frequency of nonspecific erythematous reactions. It was decided that the additional time and expense incurred by this additional test was unwarranted.

All personnel had routine pre-affiliation chest x-rays which were repeated annually or more frequently as indicated. Initially positive tuberculin reactors were questioned regarding prior test results. Their chest x-rays were repeated at three, six-month, or yearly intervals as individually warranted.

All negative reactors were retested at three- to four-month intervals while affiliated or employed at the hospital. Table 2 illustrates a summary of the various groups tested.

During the period of study, seven persons were found to have converted from negative to positive tuberculin reactors and were placed on INH therapy. There were five student nurses, one employee, and one resident physician.*

The criterion for determining conversions was a 9 mm or larger indurated, elevated skin reaction to the 0.0002 mgm PPD dose in an individual with recently negative tests, subsequently reproduced on a repeated dose after three to seven days. This criterion was adopted upon the advice of Dr. Robert Marks,[1] who, simultaneously engaged in a tuberculin study in Honolulu school children, had questioned the value of the 6 to 8 mm skin reaction (see discussion). By this arbitrary determination, these candidates were considered to be true tuberculin converters who had incurred their first infection.

Pre-therapy gastric washings for smears and cultures were done on three consecutive days in the seven individuals. All were negative for tubercle bacilli. Chest x-rays which routinely had been taken every three to four months were, after conversion, taken monthly for three months and thereafter at three-month intervals. With one exception (resident physician), the chest x-rays on all have remained negative for evidence of pulmonary tuberculosis.

All tuberculin converters, as confirmed by retesting, were started on a nine-month course of INH, taking a 100 mgm tablet three times a day with meals. With the exception of the resident physician as noted, follow-up tuberculin tests were done in six of the seven converters.

It is interesting to note that four of the six converters had a complete reversal of their former positive tuberculin test while on INH therapy. The earliest reversal was noted during the fifth month of therapy; two reversed during the eighth and one during the ninth month of treatment. A total of 38 negative tuberculin tests, 13 of which were with the 0.005 mgm dose, over a period from five to 24 months, have been obtained on these four reversals. One converter remains a positive reactor to date, four months after completion of a course of INH, while the remaining converter has to date been on therapy only four months and still remains a positive reactor.

Discussion

As indicated earlier, the use of INH in this study was undertaken to prevent or minimize the chances of primary infection evolving into active disease in a group, some of whom by former "watch and wait" methods developed significant disabling tuberculosis.

As the study progressed, the literature reviewed was abundant and oft-times confusing regarding the use of INH as a "chemoprophylactic" or "prophylactic" agent. In some articles it was obvious that these words meant "preventing or minimizing

* The resident physician, who previously had negative tuberculin tests, acquired her infection by accidentally puncturing her finger while performing an autopsy on a tuberculosis patient. Subsequent axillary glandular enlargement and development of a positive tuberculin test one month later indicated she had acquired her primary infection in this manner. Simultaneous chest x-rays were considered suspicious when compared with two prior negative films. Her gastric studies were negative. Provided with INH medication, she shortly afterwards left St. Francis Hospital for further training on the mainland. Whether she continued her medication as prescribed has not been ascertained. When last reported, she had successfully undergone surgical removal of the tuberculous axillary glands.

[1] Marks, R. H., Tokuyama, G., and Peterson, A.: A five-year study of tuberculin testing in Honolulu schools, Am. Rev. Tuberc. 78:871 (Dec.) 1958.

the evolution of primary infection into active disease." In others, they were used in the probably correct semantic connotation—that of prevention of the primary infection. This terminology should be clarified.

Whether INH therapy in our early converters with definite but undetectable infection has resulted in healing with loss of reactivity is hopeful, but hazardous to assume. Spontaneous reversal of tuberculin positive reactors has been reported, but chiefly in infants and young children. Dahlstrom[2] pointed out the instability of the tuberculin reaction and the high reversal rate in children, but noted this to be rare in adults. More recently, Adams *et al.*[3] reported on 160 recent converters (84 per cent under 16 years and 50 per cent under six years of age). Sixty-eight or 56 per cent of these reactors, when followed by repeated tuberculin tests, reversed from a positive to negative reaction.

Similar to Dahlstrom's observations, the proportion of reversions seemed to bear a direct relationship to the degree of initial positive skin reactivity, that is, 76 per cent of the 1+ (NTA standard) and 50 per cent of the 2+ converters showed reversals on repeat tests, while only 38 per cent of the 3+ and only one of the 4+ reactors reversed. Although some of these converters were treated with INH, no data are available on reversals in this group.

In the same study, when guinea pigs inoculated with M. tuberculosis were treated with INH, their skin reactivity was reduced when compared to untreated controls. If INH treatment was begun at time of inoculation, some animals failed to develop a positive reaction and all had negative spleen cultures. If treatment was delayed three weeks after inoculation, all developed weakly positive (1 to 2+) skin reactions and a few showed signs of tuberculosis by autopsy and by culture. The infected untreated animals all showed signs of severe tuberculosis and uniformly developed 4+ skin reactions.

Robinson, Myer, and Middlebrook[4] have reported reversal of the tuberculin skin test in four out of six infants treated with INH for less than eight months. All six infants had roentgenographically negative chests. Another group of seven infants with chest x-ray evidence of tuberculosis remained positive reactors after seven months of isoniazid therapy. Untracht, Ratner, and Asung[5] likewise noted reversals after three months of INH therapy in three children who showed minimal or no roentgenographic evidence of pulmonary infection.

Marks *et al.*,[1] in a Honolulu survey of 22,958 school children five to 18 years of age, showed a "reversion rate" of 12.4 per cent of untreated previously positive reactors. He noted the difficulty in evaluating the "borderline" group of 6 to 8 mm reactors and thus the relative inexactness of the tuberculin reaction in differentiating those who are infected with tubercle bacilli and those who are not. He suggested that most reactions in this "borderline" group represented nonspecific reactions and should not be considered infected.

Ferrebee *et al.*,[6] in a coordinated U.S. Public Health Service investigation of 2,750 children with asymptomatic primary tuberculosis, noted a slight decrease in cutaneous reactions in both INH treated and untreated groups after 12 months of study. Cutaneous reactions of less than 5 mm at 12 months were observed among children whose initial reaction was not more than 10 mm and whose chest x-rays were negative. They also suggested that the initial reaction in some of these children was nonspecific and not indicative of tuberculous infection.

Walker[7] in his concluding remarks on tuberculosis in Hawaii in 1953 stated, "It is important to know the significance of first infection in adults as compared with children . . . . the time has come when it should be recognized that tuberculous infection means the beginning of disease which all too frequently becomes serious if not fatal. Accordingly, serious consideration should be given to the treatment of the disease with chemotherapy at the earliest possible moment, as is done in the case of syphilis."

The crux of the problem is how can we recognize primary infection "at the earliest moment?" The use of the tuberculin test at frequent intervals seems the only practical method available. Its value is further enhanced when it is positive in a recently negative reactor, indicating early infection. Accordingly, it could be an indication to start treatment. Caution in relating weakly positive reactions to infection appears warranted, however, until further study has clarified their significance.

Despite the controversies regarding tuberculin reversion, loss of immunity, emergence of resistant strains of organisms, and their relation to the management of the tuberculin converter,[8] it may well

[2] Dahlstrom, A. W.: The instability of the tuberculin reaction, Am. Rev. Tuberc. 42:471 (Oct.) 1940.

[3] Adams, J. M., Kalajan, V. A., Mork, B. O., Rosenblatt, M., Rothrock, W. J., and O'Loughlin, B. J.: The reversal of tuberculin reaction in early tuberculosis, Dis. Chest 25:348 (Apr.) 1959.

[4] Robinson, A., Myer, M., and Middlebrook, G.: Tuberculin hypersensitivity in infants treated with isoniazid, New Eng. J. Med. 252:983 (June 9) 1955.

[5] Untracht, S., Ratner, B., and Asung, C.: Reversion of tuberculin hypersensitivity in children treated with isoniazid, Seaview Hosp. Bull. 16:116 (Jan.) 1957.

[6] Ferrebee, S. H., Mount, F. W., and Anastasiades, A. A.: Prophylactic effects of isoniazid on primary tuberculosis in children, Am. Rev. Tuberc. 76:942 (Dec.) 1957.

[7] Walker, H. H.: Tuberculosis in Hawaii, Am. Rev. Tuberc. 68:839 (Dec.) 1953.

[8] Bellamy, W. E., Jr.: Management of the tuberculin converter, J.M.A. Georgia 47:394 (Aug.) 1958. Editorial, New Eng. J. Med. 251:716 (Oct. 21) 1954.

be that regression of disease in a minimally infected person may be enhanced or catalyzed with specific treatment.

While perhaps too early to be clearly significant, it is important to indicate that in my experience at St. Francis Hospital, where, since 1946, I had participated in the student nurse tuberculosis problem, this three-and-one-half-year program utilizing more frequent tuberculin tests, and INH therapy in the recent definite converter, is the longest interval in which active tuberculosis has not been detected in this group.

Summary

The hazard of active tuberculosis in nurses and physicians in a general hospital is indicated.

An effective anti-tuberculosis program is outlined, utilizing frequent tuberculin tests, and isoniazid therapy in confirmed recent converters. INH was used in this study to prevent or minimize the chances of primary infection evolving into active disease.

All hospital personnel were included; however, this study centered on student nurses because of their higher morbidity and relative ease in follow-up. There is a lack of reports in the medical literature on such a group in which recent converters have been so treated.

In the ten years prior to the initiation of this study, seven clinically active cases of pulmonary tuberculosis developed in student nurses during or shortly after completion of their three-year curriculum.

The past three and one-half years under a more intensive program of early detection and INH treatment of primary infection is the longest interval in which active tuberculosis has not been detected in this group.

Summario in Interlingua

In 5.000 tests cutanee a purificate derivato de proteina pro tuberculose, effectuate in le personal de un hospital general in le curso de un periodo de dece annos, conversiones ab negative ad positive esseva constatate cinque infirmeras studentes, un medico, e un empleato laic. Sex del subjectos esseva tractate con isoniazido in le supposition que le conversion resultava de un tuberculose precoce de forma non clinicamente detegibile. Tuberculose manifeste non occurreva in ulle del casos. In quatro casos, le positivitate del test cutanee reverteva a un reaction negative. A nulle previe tempore de su historia ha le hospital habite un equalmente longe tempore—i.e. tres annos e medie—sin le declaration de tuberculose manifeste in un del infirmeras o empleatos.

1697 Ala Moana

On Percussion

During percussion the shirt is to be drawn tightly over the chest, or the hand of the operator covered with a glove made of unpolished leather.

If the naked chest is struck by the naked hand, the contact of the polished surfaces produces a kind of noise which alters or obscures the natural character of the sound.

Leopold Auenbrugger
Inventum Novum ex Percussione Thoracis Humani
Trattner, J.T., Vienna, 1761

Pertussis is not easy to diagnose, prevent, or treat—

but here are some useful suggestions which may help you

Pertussis

JOHN R. STEPHENSON, M.D.,* Honolulu

PERTUSSIS IS a disease of infants and children characterized, as the Latin components of the word imply, by a severe cough. It is caused by the bacterium Bordetella pertussis.[1] The disease is extremely contagious, comparable in this respect to varicella and measles, and produces serious illness, particularly in young infants. In Hawaii we have a large, relatively unprotected population, and among the medically indigent, families tend to be large and live under crowded conditions. Since the disease is present here, one would expect the incidence to be high, and it is therefore surprising to find that this is not the case, at least as judged by reports to the Department of Health. Such reports however may give an erroneous picture of the true incidence, because (1) the proper etiologic diagnosis may often not be made; and (2) if it is made it may not be reported to the Department of Health. It is possible too that there may be incompletely understood controlling factors in our population or environment.



DR. STEPHENSON

Case Report

On August 1, 1959, a 3½-month-old Hawaiian infant from Oahu was admitted to The Queen's Hospital as a suspected case of pertussis. The child had experienced a large-macular exanthem accompanied by fever, irritability, and coryza which lasted four days, two weeks before this admission. This illness was thought to have been measles, although known or suspected contact was denied and no siblings experienced a similar disease. At the same time, a cough of progressive severity developed, eventually becoming so severe with prolonged paroxysms that the baby "ran out of breath and choked." The cough was stimulated by crying, feeding, or startle, and frequently terminated by emesis. These features were so severe that baby was continually exhausted and weak from lack of nourishment.

The day before admission he was seen in the outpatient department of The Queen's Hospital where he was noted to have clinical signs of bronchopneumonia and was given 400,000 units procaine penicillin and 0.5 gm streptomycin. The next day he was no better and looked pale and lethargic. The classical pertussis paroxysmal cough was then noted and admission advised. At the time it was further advised that all siblings and contacts in younger age groups be given booster doses of diphtheria-tetanus toxoid and pertussis vaccine (DPT).

On admission the patient was lethargic, drooling, and easily stimulated into paroxysmal coughing during which his face became livid and which then terminated with retching or vomiting. His eyes, ears, nose, and throat were noted to be within normal limits except for excessive mucus in the oral pharynx. There were no conjunctival petechiae. The chest was well developed and symmetrical with good bilateral expansion and exhibited no retraction. Coarse rhonchi were heard bilaterally but no fine rales were noted. The heart was judged to be normal except for tachycardia. The abdomen was soft and no organs or masses were felt. The skin, genitalia, extremities, and neurologic examinations were unremarkable.

His temperature was 99.6° F., pulse 120, red count 4,589,000, hemoglobin 12.6 gms., packed cell volume 42, white count 26,400, lymphocytes 77 per cent, polys 23 per cent. His urine was normal. A nasal pharyngeal swab was obtained on admission and revealed an abundant growth of Bordetella pertussis on the third day.

He was treated with chloramphenicol, hyperimmune gamma globulin,† sedation, thickened feedings and careful nursing care. His response was dramatic; the paroxysms became not only less severe but less frequent. He continued post-tussive vomiting but was able to be re-fed and generally retained the feedings. He rested quite comfortably and by the fourth hospital day was deemed well enough controlled to go home. A discharge blood count revealed a white count of 12,850 with 98 percent lymphocytes and 2 percent neutrophils. Chloramphenicol was discontinued on the fifth day and daily clinic visits testified to the baby's gradual recovery. He had two relapses of severe paroxysmal coughing; each time the mother had neglected to administer the prescribed sedative. He was readmitted to the hospital six weeks after the onset of this illness for an unrelated problem and was noted to still have the typical paroxysms of cough.

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[1] Bergey's Manual of Determinative Bacteriology, ed. 7, William & Wilkins Co., Baltimore, 1957. This organism, along with Bordetella parapertussis, was formerly classified under the genus Hemophilus. The third member of this new genus (Bordetella bronchiosepticus) was formerly called Brucella bronchiosepticus.

Clinical Diagnosis

This case illustrates most of the classical signs and symptoms of pertussis: the fairly long prodromal period of coryza and mild cough, becoming increasingly severe and occurring as paroxysmal, rapid, repeated coughs terminating (in the infant) in retching or vomiting. Classically in the older child, a whoop, or loud inspiratory breath terminates the attack (the typical whoop is not heard in young infants). The child's face quite characteristically becomes suffused and even cyanotic and he is left exhausted by one attack and terrified of the next one. These paroxysms are triggered by a variety of trivial stimuli, including swallowing food or water, laughing, crying, startle, or sudden change in temperature.

Physical findings in addition to those presenting in this child are subconjunctival hemorrhages, and a thick tenacious pearly white nasopharyngeal discharge which sometimes strings out in rope-like cords. There are frequently signs of bronchopneumonia both clinically and radiologically. The abdomen, particularly in infants, is sometimes distended, and dehydration and acidosis may be noted.

Confirmatory laboratory findings are a mild to moderately severe leucocytosis (15,000 to 35,000 or higher) and marked lymphocytosis (70 per cent to 95 per cent). The organism, as discussed below, is extremely difficult to culture but lack of this bit of evidence does not militate against the diagnosis. Infection with Hemophilus influenza, Bordetella parapertussis, and Bordetella bronchisepticus can be confused clinically with pertussis,[2] these diseases generally being milder and shorter in duration. There have been two cases at the Kauikeolani Children's Hospital during this year with the classical signs and symptoms of pertussis, from whom H. influenza was the only significant pathogen isolated, one time from the blood and one time from the oral pharynx.

History Not Ancient

The characteristic cough in this disease makes the clinical diagnosis of it relatively easy, and no such cough was described, at least in epidemic proportions, in Western Europe, until the late middle ages.[3] De Baillau in 1578 described the symptoms and communicable nature of the disease in the children of three Parisian physicians.[4] Subsequently, great waves of the disease passed over Europe from the 16th to 17th centuries, and by the 19th century it was endemic in all of Europe, Africa, and the Americas. Because of its extremely great communicability, it was considered caused by "contagion" long before Bordet and Gengou made their discovery of the etiologic agent in 1902.[5] It was from the name of Jules Bordet, Nobel Laureate of 1919, that the new name of this genus was derived.

Culture Is Feasible

The growth requirements of the organism are fastidious, calling for extreme care on the part of the bacteriologist. The complex medium[6] must be freshly prepared with whole blood, and the specimen must be immediately cultured. It takes two to four days to grow the organism and another day to identify it positively. The best source of inoculum is from a nasopharyngeal swab, ideally in place during a coughing paroxysm. The swabs are made from short pieces of #30 surgical wire, cotton tipped as an applicator stick. The wire is generally passed through a nostril to the posterior nasopharyngeal space where it is left in place for twenty to thirty seconds. The procedure is not uncomfortable and all but infants and young children will tolerate it without objection. Once obtained, the swab must be immediately sent to the laboratory and plated within ten to fifteen minutes. It is wise to forewarn the laboratory to have the medium made and ready. Ideally, one would have the culture medium sent to the office, clinic, or bedside and plate the inoculum immediately after obtaining it. A more recent innovation which enhances the bacteriologists' ability to detect these organisms is to streak the swab through a drop of penicillin placed in the surface of the culture medium so that penicillin-sensitive organisms will be inhibited and the pertussis colonies more easily seen.[7]

Compounding the difficulty in growing the organism is the relatively short period of the disease during which it can be isolated. If the entire course of the disease is considered as divided into three parts, prodromal, paroxysmal, and convalescent stages, each lasting about two weeks, it is generally recognized that isolation of the organism is extremely difficult any time after the onset of the second or paroxysmal stage. Lawson reported 71 per cent isolation from known cases during the first stage, 18 per cent during the first week of the second stage, and only 2 per cent isolation rate thereafter;[8] thus, it is already very late to isolate

† Pertussis Immune Globulin (Hyland Laboratories).

[2] Bradford, Wm. L.: in Bacterial and Mycotic Diseases of Man, edited by Rene J. Dubos, ed. 3, J. B. Lippincott Co., Philadelphia, p. 490, 1958.

[3] Griffith, J. P. C.. in An American Textbook of Diseases of Children, edited by Louis Starr, W. B. Saunders Co., Philadelphia, p. 202, 1895.

[4] Major, Ralph H.: Classic Descriptions of Disease, ed. 3, Charles C. Thomas Co., Springfield, p. 210, 1945.

[5] Griffith,[3] p. 203.

[6] Bordet-Gengou Medium, Dehydrated, obtained from Difco Co., Detroit.

[7] Bradford,[2] p. 490.

[8] Lawson: cited in Mitchell—Nelson, Textbook of Pediatrics, ed. 5, W. B. Saunders Co., Philadelphia, p. 495, 1950.

the organism by the time the disease becomes obvious by clinical signs and symptoms.

Treatment Discouraging

Treatment of this disease in this day of wonder drugs remains discouraging. Chloramphenicol and tetracycline are reportedly the drugs of choice; however, neither is dramatic. This may be due to the fact that the organism is eliminated quite early in the course of the disease, and further manifestations may be due to toxic products of the organism, against which antimicrobials are, of course, ineffective.

The extreme lymphocytosis appearing early in the paroxysmal stage, and the hyperirritability of the cough reflex, may be due to toxins. There is commercially available a gamma globulin, hyperimmune to pertussis, which has been recommended.[9] It must be used repeatedly during the acute stages of the disease for maximal benefit.

There is some suggestion that stimulation of the immune mechanism by anamnesia, in previously immunized persons who have acquired the disease, by giving vaccine during the course of the disease, is of value.

Most clinicians will agree on two things, however: that the disease in infants is extremely serious, requiring hospital care; and that good, patient nursing care is the most important therapeutic aspect in the recovery of the pertussis patient.

Complications Are Serious

Complications of the disease and residua account for the great seriousness of pertussis. The interstitial bronchopneumonia so commonly seen is probably part of the basic disease. Otitis media, particularly in younger children, is commonly due to secondary invaders. Atelectasis due to mucus plugs blocking off small bronchi, and emphysema, varying from simple peribronchial to mediastinal and subcutaneous emphysema of the neck and face, are serious complications. Pneumonia due to aspiration during the paroxysm, and residual bronchiectasis, are occasionally seen. Prolapse of the rectum and herniation are sometimes seen resulting from the straining. Abdominal distention, particularly in young infants, is a serious complication.

By far the most serious, however, are the complications and residua found in the central nervous system. There is a very high incidence of abnormal EEG records after recovery from pertussis, and a small number of children will have seizures during the worst period of their disease. Particularly in infants are permanent nervous system deficits seen, such as hemiplegia, mental retardation, paralysis, etc., presumably due to hemorrhage during paroxysms. Malnutrition, particularly in the infant, may be a serious problem.

Prevention Is Important

Prevention of disease rests on two premises: immunization of susceptible persons and isolation of known cases. Pertussis immunization is probably the most difficult procedure of its like in current use. Not only is there a high degree of reaction both locally and systemically to the vaccine, but antibody production seems not to be as effective in prevention as in other diseases. The development of effective, safe vaccine has been difficult but finally achieved, and the combined diphtheria-pertussis-tetanus and plain pertussis vaccines in current use are to be strongly recommended. After the initial immunization procedure, booster doses should be given up to the age of four years, after which pertussis vaccine is not recommended, chiefly because of the profound systemic reactions occasionally seen.[10]

Patients with pertussis and their siblings should ideally be kept from contact with other children; particularly newborn infants should be protected from exposure. Because of the severity of the disease in the very young, pertussis vaccination in the newborn nursery has been carried out and is recommended during epidemic periods or in highly endemic areas.

The last reported death due to pertussis in the Hawaiian Islands was in 1953.[11] During 1958 there were only five cases of pertussis reported to the Department of Health, but between March and June, 1959, 20 cases were reported,[11] with a total of 29 cases for 1959. The case reported here is the only one known to have been bacteriologically proved for several years. Again it should be emphasized that although obtaining positive culture is ideal, ideal conditions do not frequently prevail and the disease remains the same, regardless whether it is proved bacteriologically or not.

Summario in Interlingua

Pertusse es difficile a prevenir e serie quando illo occurre. Le culturation de Bordetella pertussis ab le gurgite es practicabile si grande attention es prestate al detalios technic. Le tractamento es discoragiante. Chloramphenicol e tetracyclina es le antibioticos preferite, e globulina gamma ha essite recommendate. Proteger infantes contra le exposition es un importantissime mesura.

[9] Hypertussis, obtained from Cutter Laboratories, Oakland, Calif., or Pertussis Immune Globulin, obtained from Hyland Laboratories, Los Angeles, Calif.

[10] Batson, R., and Christie, A.: Immunization methods and materials, J. Pediatrics, 53:51 (July) 1958.

[11] Enright, James R.: Personal communication.

Neck gland metastases may be the first sign of cancer of the nasopharynx. Irradiation is the treatment of choice.

Cancer of the Nasopharynx

L. Q. PANG, M.D., Honolulu

CANCER OF THE nasopharynx is the most malignant tumor of the upper respiratory and alimentary tract. Yet it is one that is most frequently missed in its early stages. It has been estimated that its average victim has had symptoms for three months before consulting the physician. After this, it takes another four months before the proper diagnosis is made. During this time, many unnecessary surgical procedures may have been performed. By the time the correct diagnosis has been made, metastatic symptoms may be the predominant clinical feature.



Bauer

DR. PANG

This appears to be a serious indictment against the physician. However, the early diagnosis is indeed a difficult problem. Unless one is constantly alert to its early symptoms and manifestations and keeps this condition constantly in mind and makes all-out attempts to prove his suspicions, it can very easily be missed.

Cancer of the nasopharynx makes up 1 to 3 per cent[1] of all malignant growths. Hoover[2] estimates that 675 new cases of malignant tumors of the nasopharynx may occur in the United States each year. At the St. Francis Hospital in Honolulu, it made up 3.5 per cent of all the head and neck malignancies admitted for the last four years. At The Queen's Hospital, for the same period, it was 5.8 per cent. In my experience, it is the most frequent malignancy seen in the head and neck.

The striking susceptibility of the Chinese to this disease is a fascinating but unsolved problem.[3] In Formosa, it ranks next in frequency to cancer of the genital organs; in males alone, it ranks first.[7] In my series of 42 cases, 80 per cent occurred in the Chinese. Of further interest is the fact that the Northern Chinese seem less susceptible to this disease than their Southern compatriots, though this has not been proved statistically.

Young Males Susceptible

This disease occurs more often below 30 years,

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[1] Greist, R. M., and Portmann, U. V.: Primary malignant tumors of the nasopharynx, Am. J. Roentgenol. 68:262 (Aug.) 1952.

[2] Hoover, W. B.: Malignant growths of nasopharynx with particular emphasis on their frequency, symptomatology and diagnosis, Surg. Clin. No. Am. 27:577 (June) 1947.

[3] Martinez, E.: El cancer de la nasofaringe en los Chinos, Bol. Liga Contra El Cancer, 15:276, 1949. Martin.[4] Salinger.[5] Digby.[6]

[4] Martin, H., and Quan, S.: The racial incidence (Chinese) of nasopharyngeal cancer, Am. Otol. Rhinol. & Laryngol. 68:158 (Mar.) 1951.

[5] Salinger, S., and Pearlman, S. J.: Malignant tumors of the epipharynx, Arch. Otolaryngol. 23:149 (Feb.) 1936.

[6] Digby, H. K., Fook, W. L., and Che, Y. T.: Nasopharyngeal carcinoma, Brit. J. Surg. 28:517 (Apr.) 1941.

[7] Yih, Shu, and Cowdrey, E. V.: Incidence of malignant tumors in Chinese, especially in Formosa, Cancer 7:425 (Mar.) 1954.

and is found oftener in children than any other malignant growth of the upper respiratory and alimentary tract.[8] The average age is 44 years, but 20 per cent of the cases are below the age of 30. In my series, the youngest was in a 4-year-old boy and the eldest was in a 67-year-old Chinese woman. Females make up 20 per cent of the cases.

Most Are Epidermoid

Epidermoid carcinomas make up nearly 90 per cent of the cases. These are divided in order of diminishing frequency into the transitional cell carcinoma, the lymphoepithelioma, and the squamous cell carcinoma. The sarcomas make up about 10 per cent, lymphosarcoma and the reticulum cell sarcoma being nearly equal in frequency. Malignant tumors of the salivary gland type make up a very small percentage.

Early Symptoms Rare

Cancer of the nasopharynx causes few, if any, symptoms in its earliest stages. The predominating symptoms in the order of frequency are (1) enlarged cervical nodes, (2) unilateral nasal obstruction, (3) bloody nasal discharge, (4) ear symptoms—fullness, tinnitus, and impaired hearing, (5) head and neck pains, and (6) cranial nerve involvement.

Metastatic cervical nodes are present in 65 per cent of the cases and frequently their presence is the first and only complaint of the patient. The glands most frequently involved are those below the angle of the jaw (the so-called tonsillar glands), the subdigastric nodes and those beneath the upper attachment of the sternomastoid muscle. Occasionally, the spinal accessory nodes are the first to be involved. It is my dictum that any case with an enlargement of these nodes should be considered as a cancer of the nasopharynx unless proved otherwise. Primary bilateral neck nodes are seen in 5 per cent of the cases. Contralateral neck nodes develop in 20 per cent of the cases even under treatment.

Unilateral nasal obstruction or a bloody nasal discharge is present in 40 per cent of the cases. These are relatively late symptoms.

Ear symptoms are a predominant feature of this disease. A hissing type of tinnitus is probably the earliest symptom. It was an early symptom in 30 per cent of my cases but I feel that a more careful history may reveal a much higher incidence. It preceded the enlargement of the cervical nodes in 50 per cent of the cases. The feeling of fullness in the ear may be due to a mechanical blockage of the eustachian tube or an effusion in the middle ear. It is therefore imperative that all cases with ear symptoms have a careful investigation of the nasopharynx.

Head and neck pains are not uncommon and are relatively late symptoms. They are usually due to bony erosion, intracranial extension, or fifth cranial nerve involvement. A localized pain in the occiput or nape of the neck may be seen relatively early. This was seen in two of my recent cases. In both cases, there were no palpable nodes. The lesion was situated in the most posterior portion of the nasopharyngeal vault.

Intracranial metastases occur in 40 per cent of the cases. Over 50 per cent of these cases lack x-ray evidence of bony erosion. The cranial nerves involved in the order of frequency are the sixth, fifth, third, and fourth. A paralysis of the lateral rectus muscle (sixth nerve) is present in 15 per cent of the cases. Extension of the lesion may involve the other cranial nerves. A jugular bulb syndrome, a Gradenigo syndrome, or others may result. Extension of the lesion into the orbit occurs in 4 per cent of the cases to cause an exophthalmos, ophthalmoplegia, and ocular pain. Extension of the lesion downward along the pterygoid process to involve the internal pterygoid muscle may cause a trismus (10 per cent). Further extension into the soft palate to infiltrate the levator palatini muscle may cause an asymmetry and a subsequent nasal voice.

Distant metastases below the clavicle occur in 30 per cent of the cases.[8] The organs usually involved are the bones, liver, and lungs.

Diagnosis Usually Late

The diagnosis is usually made late. Several reasons are responsible for this delay. The first is the relative lack of early symptoms. The second lies in the inability of the physician to make an early diagnosis. The literature is full of reports of cases[9] in which multiple unnecessary procedures have been carried out for relief of symptoms.

The early diagnosis will depend upon (1) a high degree of suspicion, (2) a careful examination and visualization of the entire nasopharynx of any patient presenting the symptoms enumerated above, and (3) a biopsy of any suspected lesion.

In the examination of the nasopharynx, the use of a mirror is the most satisfactory method. In 10 per cent of the cases this cannot be done even after the use of local anesthetic, and one must use a nasopharyngoscope. The nasopharyngoscope is not as satisfactory, as it gives only a limited view. It is very helpful in visualizing the lesion once

[8] Martin, H.: Diseases of the Nose, Throat, and Ear, Jackson & Jackson, W. B. Saunders, Philadelphia, Pa., 1946.

[9] New, G. B., and Stephenson, W.: End results of treatment of malignant lesions of the nasopharynx, Arch. Otolaryngol. 38:205 (Sept.) 1943.

it has been spotted. Probably its greatest use is in doing a biopsy. Palpation is unsatisfactory. Occasionally an x-ray may be helpful. X-rays of the skull should be taken in all cases where an intracranial extension is suspected.

In early cases, ulceration may not be present. The only noticeable lesion may be a slight nodular irregularity in the wall. In some cases, the fossa of Rosenmuller may be partially obliterated by irregular tissue simulating lymphoid tissue.

Every suspicious lesion should be biopsied. If the biopsy is negative, it should be repeated as long as there is any suspicion of a malignancy. There are many reports where multiple biopsies were necessary before the diagnosis was proved. In one case,[10] as many as seven were done. This is not surprising, as the nasopharynx is so often overgrown by hypertrophied lymphoid tissue or granulation tissue that it is very easy to remove these tissues instead of the lesion. Whenever a pathologist fails to find neoplastic changes in the biopsy material but finds ulceration, necrosis, or significant adenoiditis, repeated biopsies are especially indicated.[11]

Even in the presence of enlarged cervical nodes, the diagnosis is properly made by identifying the primary lesion and not by removing the node. This surgical principle has frequently been violated. If a thorough examination of the nasopharynx does not reveal a lesion, multiple biopsies often will yield a positive report.

Radiation Is Treatment of Choice

The treatment of cancer of the nasopharynx is external irradiation. There is a wide variance of method of applying it. The 250 KV equipment is still the conventional mode of treatment, although in large medical centers it is being gradually supplemented by one or two million volt radiation or the gamma rays of cobalt 60. External irradiation may be supplemented by intracavitary radium application. The latter is especially useful in treating recurrent lesions of the nasopharynx.

Most of the lesions are radiosensitive. Under radiotherapy the lesions in the nasopharynx and the cervical glands virtually melt away. There is improvement in the symptoms and general health of the patients. Unfortunately, while the lesions are radiosensitive, they are not all radiocurable. A few cases develop contralateral neck nodes even under treatment. A recurrence of the local lesion developed in 50 per cent of my cases. Unfortunately, the recurrent lesion becomes more radioresistant with each recurrence.

Certain operative procedures have been used by otolaryngologists as an aid in the treatment and in facilitating the follow-up observation of the nasopharynx. These include the partial septectomy advocated by Sooy,[12] the transpalatine operation of Hara,[13] and the palatal fenestration of Wilson.[14] I have used the fenestration of the palate in seven cases and have found it very useful in the follow-up examination of the patient. Its greatest value is in the cases where a repeat follow-up biopsy is necessary. By simply removing the prosthesis, a piece of tissue from the nasopharynx can be obtained in a matter of seconds.

While all agree that the treatment of cancer of the nasopharynx is irradiation, no such unanimity of opinion exists regarding the management of the cervical metastases. The majority feel that neck dissection is of no value because the primary lesion is usually a highly malignant anaplastic growth which tends to metastasize early and widely and may metastasize to both sides of the neck. They feel that irradiation is capable of permanently controlling a fair percentage of the cervical metastases.[15]

However, there are others[18] who feel that a combination of irradiation and neck dissection is most efficacious. They feel that while the neck dissection is not an *en bloc* dissection of the lesion, all modes of treatment should be considered in any one patient. The surgery removes the metastatic nodes while the irradiation is used to control the primary site and the intervening pathways. Before a neck dissection is contemplated, one must consider the most important fact: the uncertainty of control of the primary lesion. As mentioned earlier, 50 per cent of my cases had a local recurrence.

Prognosis Not Hopeless

Cancer of the nasopharynx carries a high mortality but it is by no means hopeless. A five-year cure rate for all patients of 25 per cent or more has been reported by Martin,[8] Lenz,[16] Schall[15] and others. Others have been more pessimistic.[19] Martin[8] has repeatedly stated that a 50 per cent cure can be expected in the early cases without cervical metastases. In my series, five-year remission of 17.5 per cent was reported but this dropped

[10] Martin, H. E., and Blady, J. V.: Cancer of the nasopharynx, Arch. Otolaryngol. 32:692 (Oct.) 1940.
[11] Chappell, Raid: Personal communication.
[12] Sooy, F. A.: Experimental treatment of recurrent carcinoma of the nasopharynx with electrodesiccation, radioactive cobalt and x-ray radiation, Am. Otol. Rhinol. & Laryngol. 65:723, 1956.
[13] Hara, H. J.: Malignant tumors of the nasopharynx, transpalatine surgical excision, A.M.A. Arch. Otolaryngol. 60:440 (Oct.) 1954.
[14] Wilson, C. P.: Observations on the surgery of the nasopharynx, Am. Otol. Rhinol & Laryngol. 66:5 (Mar.) 1957.
[15] Schall, L. A.: Malignant neoplasms of the nose, paranasal sinuses, and nasopharynx; evaluation of surgical treatment, Trans. Am. Acad. of Ophth. & Otolaryng. Pp. 209 (Jan.-Feb.) 1951. Greist,[1] Martin,[8] New,[9] Lenz,[16] Salinger.[17]
[16] Lenz, M.: Roentgen therapy of primary cancer of the nasopharynx, Am. J. Roentgenol. 48:816 (Dec.) 1942.
[17] Salinger, S., and Pearlman, S. J.: Malignant tumors of the epipharynx, Arch. Otolaryngol. 23:149 (Feb.) 1936.
[18] Woo, Henry: Personal communications.
[19] Furstenburg, A. C.: Malignant neoplasms of the nasopharynx, Surg. Gynec. & Obst. 66:400 (Feb.) 1938. New.[9]

to 12 per cent at the end of the sixth year. This lends credence to Godtfredsen's[20] contention that in cancer of the nasopharynx, a cure cannot be definitely declared complete until the patient is free of symptoms for at least nine years.

The most encouraging result is that of Smedal and Watson[21] who reported on 39 cases treated with two-million-volt x-rays. Of the 28 consecutive cases of primary disease treated by this method, 56 per cent were living after three years and 36 per cent were living after five years, without evidence of disease. They found that the presence of unilateral cervical metastases did not significantly alter the prognosis, possibly because with this method, it is possible to administer cancerocidal doses (6,000 r) to the entire cervical and supraclavicular lymph node catchment area without producing local reaction. However, in cases of bilateral node involvement, their result was poor. It is entirely possible that with the high intensity irradiation, the outlook will be much brighter.

Summary

1. Cancer of the nasopharynx is still being diagnosed too late, when metastatic symptoms may be the predominant clinical feature.

2. The early diagnosis will depend upon (a) a high degree of suspicion, (b) careful examination of the nasopharynx in patients with the symptoms enumerated, and (c) a biopsy of any suspicious lesion.

3. In the presence of enlarged cervical nodes, the diagnosis is properly made by identifying the primary lesion and not by removing the node.

4. The treatment is irradiation. The question of neck dissection is debatable.

5. The prognosis is grave but not hopeless. A 25 per cent five-year cure has been reported by several authors. A recent report on the use of a two-million-volt irradiation gives a 36 per cent five-year cure in the cases primarily treated by this method.

Summario in Interlingua

Cancere del nasopharynge se manifesta initialmente in le majoritate del casos per metastases al nodos cervico-lymphatic, sed in certe casos il es possibile deteger le lesion primari per un meticulose examine del nasopharynge mesme. Therapeuticamente, dissection cervical es minus utile que roentgeno-irradiation. Le prognose es grave sed non desperate. Un recente reporto nota un quinquenne superviventia de 36% post irradiation a duo milliones volts.

1374 Nuuanu Avenue

[20] Godtfredsen, E.: Ophthalmic and neurologic symptoms of malignant nasopharyngeal tumors, Arch.-Psych. et Neurol. Suppl. 34:1 Copenhagen, 1944. Proc. Royal Soc. Med. 40:131 (Jan.) 1947.

[21] Smedal, M. I., and Watson, J. R.: Treatment of cancer of the nasopharynx with two million volt radiation, Surg. Clin. North America 39:669 (June) 1959.

This is the second of two articles on an important aspect of pediatrics

TABLE 1.—*Number of Deaths by Age Groups in Children for the Year 1956.*

	UNDER 1 YR.	1-4 YRS.	5-14 YRS.
United States	108,183	16,603	14,899
Montana	494	87	83
Minnesota	1,776	297	262
Texas	7,262	1,138	909
Hawaiian Islands*	363	61	42

* 1954

TABLE 2.—*Per Cent of the Total Deaths in Children by Age Groups, 1956.*

	UNDER 1 YR.	1-14 YRS.	AV./YR.
United States	7.0	2.0	0.14
Montana	7.6	2.8	0.20
Minnesota	6.0	1.9	0.13
Texas	10.4	2.9	0.21
Hawaii*	15.4	3.4	0.25

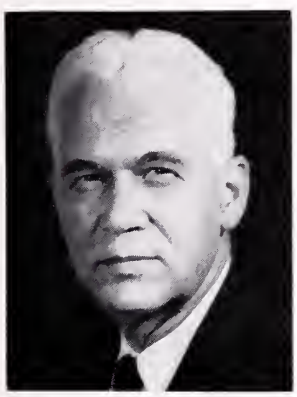
* 1954

Pediatric Emergencies: II

Emergencies of the Newborn*

ARILD E. HANSEN, M.D., Ph.D., Galveston, Texas

THE YOUNGER the child the greater the likelihood of death, as indicated from the number of deaths under one year of age as shown in tables 1 and 2. Of the deaths which occur during the first year of life some 60 per cent are in the first month, 80 per cent of which are in the first week, half of which are in the first day.



DR. HANSEN

In the consideration of neonatal deaths we have those conditions which may be anticipated from the history, those which may be expected from pertinent facts associated with the delivery and those which characteristically occur in newborns.

Conditions anticipated from the history: Rh negative mother; jaundice, blood incompatibility, maternal illness, infection, eclampsia, diabetes, multiple births, prematurity, postmaturity, premature rupture of membranes, polyhydramnios, and administration of drugs such as pituitrin, sedatives in large doses, and steroids.

Expected with delivery: prolonged labor, difficult extraction, face or breech presentation, excessive bleeding, cesarean section, placenta previa, abruptio placenta, polyhydramnios, twins, and prematurity.

Conditions which should be especially looked for in neonate: erythroblastosis fetalis, blood loss through cord, asphyxia, intracranial injury, subdural hematoma, prematurity, postmaturity, and convulsive seizures which may be due to trauma, infection, tetanus or aberration in vitamin B_6 metabolism.

To assist in caring for the emergencies of the neonate one should also be aware of the causes of death in the newborn period. From the data of Bundeson and Potter and co-workers[1] concerning over 10,000 neonatal deaths, we find the following as the causes of death during the first month of life—abnormal pulmonary ventilation 44 per cent; injuries at birth 17 per cent; malformations 16 per cent; infections 13 per cent; blood dyscrasias 5 per cent; anoxia 4 per cent; and a miscellaneous group of 1 per cent. These disorders were responsible for about 90 per cent of the total deaths which occurred in the first month of life.

* This represents a continuation of the paper entitled "Pediatric Emergencies" which appeared in our previous issue.

[1] Bundeson, H. N., Potter, E. L., Fishbein, W. I., Bauer, F. C., and Plotzke, G. V.: Progress in the reduction of needless neonatal deaths, Annual Report of the Chicago Health Department, 1951. J.A.M.A. 148:907 (Mar. 15) 1952.

Naturally, it is necessary for us not only to pay attention to the conditions which are likely to cause death, but also to consider those which may cause permanent disability. Recently, Dr. Arr Nell Boelsche, Miss Robertine St. James, and I[2] went over the neonatal histories of some 250 children with cerebral palsy from the Moody State School for the Cerebral Palsied Child. As controls we obtained similar historical data from the mother concerning the child who was immediately older or immediately younger than her offspring with cerebral palsy. In infants with cerebral palsy in only 10 per cent was the birth and prenatal history considered normal, in contrast to 61 per cent for the control group. The following features were found to be especially important: prematurity; anoxia; jaundice in the first 48 hours in many instances due to erythroblastosis fetalis; complicating obstetrical factors such as precipitate delivery, prolonged labor, and breech presentation.

We may now consider some clinical features which are characteristic of the newborn period.

Nervous System

Collapse, shock, intracranial injury, subdural hematoma, spina bifida.

Genitourinary System

Extrophy of bladder, pseudohermaphrodism.

Cardiovascular System

Congenital heart lesions, vessel anomalies.

Hematologic System

Erythroblastosis fetalis due to Rh factor or ABO incompatibilities; positive Coombs' test is very significant as an index for exchange transfusion. Hemorrhagic disease.

Endocrine System

Congenital goiter may cause choking; congenital cretinism should be suspected early; adrenal insufficiency where excessive urination can be elicited in a large portion of cases very early; diabetic mother, difficulty must be expected in a large proportion of infants.

Infections

Premature separation of membrane and prolonged labor are indications for the employment of prophylactic antibiotic therapy because of the great possibility of infection acquired in utero. Meningitis—coliform bacteria often are causative. The symptomatology may be very obscure, but this condition must be suspected. One must be ever aware of the possibility of sepsis in the neonate; hence blood cultures should be taken. Staphylococcal infection in the newborn is one of the greatest problems facing the medical world today. To eradicate and prevent infection from the hospital nursery requires the highly skilled and cooperative endeavors of all hospital personnel, the obstetrician, and the pediatrician.

Respiratory System

Pulmonary ventilatory disease is the chief cause of respiratory difficulty in newborns. The development of respiratory distress some hours after birth should make one suspect the possibility of hyaline membrane disease, especially in premature infants and those born by cesarean section. Atelectasis may contribute or by itself cause respiratory difficulty. Oxygen with a fine mist may be helpful.

Choanal atresia—difficulty in the first attempts to swallow should make one suspect the possibility of choanal atresia. Patency may be tested with 1 per cent methylene blue or by the use of lipiodol and x-ray. The use of a dropper or gastric feeding may be necessary to maintain nutrition. May require tracheotomy if atresia is bilateral.

Tracheo-esophageal fistula—the presence of copious mucus, pooling of frothy secretions, cough, sputtering, cyanosis, and dyspnea should compel one to think immediately of this possibility as a cause of symptoms which appear at the first feeding. It is necessary to insert a tube into the esophagus. If resistance is encountered, it is well to check with x-ray using lipiodol or other contrast media, but preferably not barium. The thoracic surgeon should be obtained immediately as the chance of success is greater, the earlier the operation is performed.

One may encounter congenital absence of one lung or aplasia of the lung and even pneumonia may occur in the neonate.

Gastrointestinal System

Tracheo-esophageal fistula is discussed above. The following intestinal disturbances may produce emergency situations in the neonate: perforation of the stomach or intestines, atresia or stenosis of the duodenum and intestines, malrotation of the bowel, diaphragmatic hernia, meconium ileus, imperforate anus. In addition one must be ever aware of the presence of diarrhea in the newborn. The occurrence of one case of diarrhea in the newborn nursery should alert one to the possibility of an epidemic; two cases, adoption of strict isolation; three, close the nursery and establish a new clean one.

[2] Boelsche, A. N., Hansen, A. E., and St. James, R.: Factors in the prevention of cerebral palsy, South. Med. J. 50:1294 (Oct.) 1957.

Metabolic

The presence of early jaundice should always bring to mind the possibility of galactosemia. The development of cataracts and the detection of sugar in the urine should make one highly suspicious and special tests should be made to rule out this condition. A milk free diet is indicated, otherwise severe degeneration will occur.

Diabetic mother—these infants should always be placed on the serious list.

Myasthenia gravis in the neonate will respond readily to prostigmine therapy. The mother with myasthenia gravis is likely to have an infant with this disorder.

Iatrogenic

Many conditions could be prevented by the physician being alert to conditions which are detrimental to the neonate. These include character of the anesthesia, the prevention of over-sedation, administration of pituitrin, and injury from instrumentation. By all means avoid any shortcuts which are directed at anything other than features of interest to the patient.

Accidents

One must be always on the alert for accidents in the infant.

Poisoning

In infants, poisoning can result from overdosage or the administration of the wrong medicine.

Emotional

As soon as the infant is born there is the potentiality of an emotional problem which may occur in the family.

Congenital Anomalies

At times these require emergency treatment.

Asphyxia Neonatorum

This condition deserves special consideration. Resuscitation of the newborn may be very easy or occasionally difficult. Stages of asphyxia according to Flagg are depression, spasticity, and flaccidity. The causes of asphyxia neonatorum may be as follows:

Maternal—disease of heart, lungs, kidney, intestines or liver, infections, anemia, metabolic disorders (thyroid, diabetes, dietary deficiency diseases), toxemia of pregnancy, mothers over 40, primiparity, uterine tetany, contraction ring, hemorrhage.

Fetal—prematurity, abnormalities of fetus, congenital anomalies of respiratory and vascular system, diaphragmatic hernia, congenital diseases (syphilis and erythroblastosis fetalis), abnormal presentation (breech, transverse and face), placental abnormalties, infarction, placenta previa, cord abnormalities (prolapse, compression, knotting).

Obstetric—pituitrin, quinine; prolonged and difficult labor; version and extraction, breech, mid-forceps, cesarean section; analgesia and anesthetics; morphine, meperidine (Demerol), barbiturates; general anesthesia; regional anesthesia with drop in maternal blood pressure.

It is important to evaluate the newborn immediately after birth. Apgar's[3] criteria considering heart rate, respiratory effort, muscle tone, reflex irritability, and color are very helpful (Fig. 1).

Sign	0	1	2
Heart Rate	Absent	Slow (below 100)	Over 100
Respiratory Effort	Absent	Slow, irregular	Good, crying
Muscle Tone	Limp	Some flexion of extremities	Active motion
Reflex Irritability (response to catheter in nostril)	No response	Grimace	Cough or sneeze
Color	Blue, pale	Body pink, extremities blue	Completely pink

FIG. 1.—Apgar's chart for evaluation of status of newborns.

Sixty seconds after the *complete* birth of the infant (disregarding the cord and placenta) the following five objective signs are evaluated and each given a score of 0, 1, or 2. A score of ten indicates an infant in the best possible condition. Infants with scores of five to ten usually need no treatment. A score of four or below indicates the need for prompt diagnosis and treatment. Approximately 90 per cent of normal infants should score seven or more one minute after birth.

Many techniques have been advocated for treatment of asphyxia. These include manual (not good), rocking bed, artificial hypothermia, electrophrenic stimulation, tank, air-lock, positive pressure, mouth to mouth (this is always available and is, perhaps, the safest), and endotracheal intubation with positive pressure. One must be certain not to go past the carina. Actually, intubation is of limited value.

Adjuncts to therapy are oxygen—40 per cent but for limited periods—and gastric suction, carefully performed. Especially important after cesarean section.

[3] Apgar, V.: A proposal for a new method of evaluation of the newborn infant, Current Researches in Anesthesia and Analgesia 32:260 (July-Aug.) 1953.

Drug therapy is of limited value. Alpha lobeline, coramine, metrazol are definitely contraindicated. Caffeine sodium benzoate may be used inasmuch as it is the least harmful.

Higgins in England recommends this procedure following delivery: "Place infant on right side in head-down position, use no suction, no artificial respiration, and no resuscitation." In nearly 2,000 deliveries he had no fetal mortality which could not be explained at autopsy. He found no anoxia or CNS hemorrhage.

Treatment program: (1) prophylactic prenatal care, avoid over-sedation of mother, flush mother with oxygen at delivery, let cord pulsate, (2) keep infant's head down, (3) maintain airway, gently removing blood and mucus from the nose and throat with suction, (4) handle with care and maintain body heat, (5) oxygen, (6) resuscitation—method of choice, (7) do not harm baby. I strongly recommend that every physician dealing with the newborn procure a copy of *Resuscitation of the Newborn Infant.**

* Copyright 1958. Available from the American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Illinois.

It is important that the developmental sequence of each child be followed carefully for the early detection of retardation. It is possible this way to prevent the occurrence of emotional problems which may develop later. It is important to check for developmental disorders by careful neurological examination and to prevent the development of psychological problems.

Conclusion

It is possible to deal with pediatric emergencies in many different ways. An attempt has been made here to outline certain points which seem to stand out as being particularly significant.

Summario in interlingua

Situationes de urgentia con que le pediatro pote trovar se confrontate es summarisate per le autor secundo lor causas e le systemas que illos concerne. Tractamentos de urgentia es proponite.

Situationes de urgentia que representa un periculo pro le vita del neonato es summarisate per le autor. Le proponite formas de tractamento es delineate in un forma facile a consultar.

Please, Doctor!

Route your donation to your medical school through the A.M.E.F. It goes there intact, in your name—and reflects creditably on the whole medical profession in the process.

The President's Page



Bauer

DR. NISHIGAYA

The Emergency Medical Services Committee of the HMA is much discouraged and disappointed by the response of physicians to the exercises it had planned for Civil Defense.

The American Medical Association, through its Council on National Defense and its Committee on Civil Defense has stressed repeatedly the importance of medical leadership in Civil Defense medical preparedness, including the collection, transportation, sorting, and admitting of patients under disaster conditions. The American Medical Association in actively supporting Civil Defense has recently prepared a report on National Emergency Medical Care containing "recommendations with respect to the planning, training, and operational organization needed as a basis for a National Emergency Medical Care plan for the treatment and care of casualties and non-casualties prior to, during, and after a thermonuclear attack upon the United States." We must be informed and prepared. We must assume the leadership.

To date, the Hawaii Health and Medical Services has prepared a disaster plan, set up an administrative organization, and tested it in Civil Defense exercises. Supplies and equipment have been stockpiled. The Emergency Medical Services Committee has given disaster assignments to the physicians. The State Dental and Nursing Associations have assigned their personnel. The Health and Medical Services is providing a program of general orientation in first-aid station organization and operation.

I am encouraged and happy to see that so many of my colleagues are devoting so much time and energy to this activity. I urge every physician to participate because every surviving physician, specialist or general practitioner, will have a direct responsibility for the medical management and care of casualties. The individual who is supposed to know all the answers may not be alive. Each of us has his important role in Civil Defense, not only as a physician but also as a citizen of the State and Country. Our survival may depend on how effectively we fulfill this role.

Let's be as prepared as we were on December 7, 1941.

T. Nishigaya, M.D.

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[EDITORIALS]

Use–Don't Abuse–Insurance Plans!

A naive young physician remarked to us in jest a few years ago, after he had been practicing only a few weeks, that he had just figured something out. "If I have only one patient," he said, "and he has to come to me four times, that's just as good as if I had four patients!"

He was joking, of course,—and he isn't practicing medicine any more, anyway—but there was a bitter kernel of truth in what he said. What he failed to say, and perhaps to see, was that if three of the four visits are not necessary, they constitute larceny.

In the old pre-insurance days, the patient was the victim of the larceny, and he soon put a stop to it—by changing to a doctor who was competent enough, or honest enough, not to require unnecessary visits.

An insured patient, however, finds multiple visits merely a nuisance. They cost him only the price of transportation to the office, and a little time. He is not apt to object very strenuously when his own pocketbook is so little and so remotely affected.

So also with hospitalization. An insured patient will accept hospitalization willingly—indeed, he may even insist upon it—and his impatience to get home again is greatly reduced by the thought that he doesn't have to pay the bill. The effect on the premiums he pays is far too remote to influence him very much.

The result is that voluntary health insurance costs more than it should, and the excess money goes largely into the hands of the few physicians who are careless, incompetent, or unscrupulous enough to render unnecessary services, or prolong hospitalization unnecessarily. Dr. O. D. Pinkerton, elsewhere in this issue, has tabulated the extent to which these practices may affect insurance premiums.

We are confident that most physicians are too honest—and that most of those who are not are too busy—to deliberately engage in such practices. Still, the possibility of doing harm by seeing a patient too infrequently, or by failing to observe the effect of treatment, is prominent in the mind of every conscientious physician, and maintains constant pressure for added office visits (or hospital days) at the insurance company's expense.

The entry of the Federal government—and soon, no doubt, the State government—into voluntary health insurance is about to bring these practices into sharper focus than ever. Group prepayment plans are being carefully protected by their own doctors—because their abuse costs the doctors time, and time is every doctor's stock in trade. If free-choice plans are not treated with equally scrupulous consideration and honesty, they will be priced out of the market.

Thus conscience and self-interest both demand that every physician stand firm against unnecessary utilization of insurance plans. The medical profession is headed for government salaries unless we can make these plans work and keep them economically competitive. Use—*don't abuse*— insurance plans.

Aloha to Dr. Levine

Dr. Max Levine, one of America's eminent bacteriologists, retired from his position as Director of the Bureau of Laboratories on February 29 and became a consultant to the Department of Health.

He was born on April 4, 1889, in Poland and came to Boston, Massachusetts, as an infant. His life is the story of an underprivileged person utilizing the available opportunities in a new country and rising to the top in his profession.

He received a B.S. in Biology and Public Health from the Massachusetts Institute of Technology in 1912 and a Ph.D. in Bacteriology and Preventive Medicine from the State University of Iowa in 1922.

At Iowa State College, where he began his teaching career as Instructor in Bacteriology in 1913, he became the Professor in charge of that department in 1933. There he remained until the outbreak of World War II. He was also a Research Professor at the Iowa Engineering Experiment Station. He served in World Wars I and II in the Sanitary Corps, A. U. S., and was discharged as a Colonel in November, 1946.

Dr. Levine has been associated with many advances in the laboratory aspects of public health. During World War I, he developed a medium (eosin methylene blue agar) which is still used for the isolation and differentiation of dysentery and other intestinal disease–producing bacteria from the normal intestinal flora. He was a member of the committees which prepared the 10th edition of Standard Methods of Water Analysis and the 4th edition of Diagnostic Procedures and Reagents. The latter includes recommended techniques for the detection of bacteria associated with communicable diseases.

He developed methods for purification of industrial wastes, particularly those from packing houses and creameries, which are now standard procedures.

In the field of water purification, Dr. Levine studied the principles underlying the action of chlorine as a germicide—the results of his published studies have influenced the modern practices of water purification and food plant sanitization.

During World War II, he was associated with the early work in the use of antibiotics, particularly penicillin, and he developed rapid methods for determining the susceptibility of bacteria to penicillin.

In 1947, his former World War II commanding officer (Colonel A. R. Thomas, Jr.) who happened to be in charge of the Army Laboratory at Schofield Barracks, recommended Dr. Levine to Dr. Wilbar, President of the Board of Health of Hawaii, as especially qualified to organize and lead the Bureau of Laboratories at the Health Department. Dr. Levine has been in charge of the Bureau of Laboratories since its establishment in 1947.

During his tenure here he established one of the dozen or so official Salmonella Typing Centers in the United States, and also a Staphylococcus Phage Typing Center. The latter is one of the few which have been able to maintain their phage strains and stay in business.

He belongs to many professional societies. At the request of the Society of American Bacteriologists, Dr. Levine prepared a 970 page "Compilation of Culture Media for Cultivation of Microorganisms" which was published by the Society as Volume II of its monographs on Systematic Bacteriology. He is also the author of over 200 papers on intestinal bacteriology, water and sewage purification, food technology, disinfectants, antibiotics, Hansen's disease, and other subjects.

His textbook "Introduction to Bacteriological Laboratory Technique" was first published in 1927; the second edition (1933) went through 22 reprintings; and the book is now in its third edition (1954).

He has addressed the local medical technologists on a number of occasions and their qualifications were carefully scrutinized by the Advisory Committee on Licensure of Laboratory Directors and Technicians in Hawaii, of which he is chairman. His influence has been widely felt in laboratory activities. He has also addressed numerous meetings of pediatricians and other physicians.

Hawaii is healthier, wealthier and wiser for having had Dr. Levine here these past 13 years; we regret the necessity for his retirement and are grateful that he can stay on the job as a consultant. On July 1, a testimonial dinner is to be held by his friends to honor this distinguished scientist on his official retirement. Aloha, Dr. Max Levine!

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1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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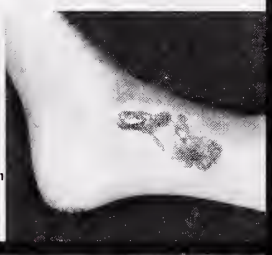
severe bruises ... swelling ... cleared by fifth day[2]





VARICOSE ULCER

15 years duration ... resolved with VARIDASE[1]





INFLAMMATORY DERMATOSIS

rapidly spreading rhus dermatitis healed within a week[1]





INFECTED LACERATION

marked reversal in 3 days... returned to school... closure advanced[1]





THROMBOPHLEBITIS

back on his feet in a week after recurrent episode[1]





REFRACTORY CELLULITIS

normal routine resumed after 4 days of VARIDASE[1]



Bureau of Medical Economics

Data Processing of Doctors' Accounts

"We feel that we now have a system which, for the first time in our many years of practice, gives us adequate control and analysis of our accounts."

This report comes from Drs. Maurice A. de Harne and H. M. Chandler at the Wahiawa Clinic who, six months ago, installed an office procedure befitting the age of automation.

In the November-December, 1959, issue of the JOURNAL (page 183) we reported that progress was being made in the use of data processing of doctors' accounts. We are glad to report that users here in Hawaii are very pleased with the results obtained.

The recent announcement that Hawaii Medical Service Association (HMSA) will be able to accept claims processed through this new system is most welcome news to all doctors. (This will be possible by the end of 1960.) A verbal lei of gratitude is extended to HMSA for their assistance in making this possible to the benefit of the medical profession in Hawaii.

Due to the importance of this new system to the doctor the balance of this month's *BME News* is devoted to the outline of the system and its many advantages to the doctor and his staff.

Importance to the Doctor: "Automation of our bookkeeping has improved collections and relieved the office staff of all preparation of monthly statements.

"Expense of the system has been reasonable and well worth the detailed business analyses we receive of our monthly records."

Data on Tape: The set-up consists of a small, simple-to-operate posting machine which can be used, without special training, by anyone able to operate an adding machine. It is equipped with a special attachment which translates information about patients' accounts into a code language which can be understood by high-speed, automatic equipment located in a central office.

As in many offices, Wahiawa Clinic's system begins with a fee slip which is made out for each patient. The charges are entered opposite the description of services.

At the end of the day, the nurse-bookkeeper assembles the fee tickets and begins posting. Through the adding machine keyboard the operator simply records fees and payments on patients' account cards. THIS IS THE ONLY BOOKWORK SHE EVER HAS TO DO concerning patients' accounts.

As she records the charges and payments, the tape machine punches out the following information:

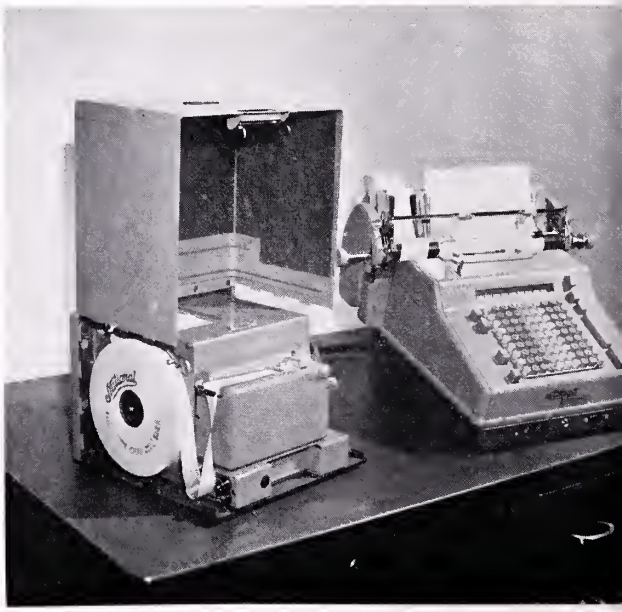
- Description number of the charge, or payment.
- Amount of the charge, or payment.
- Patient's identification number.
- Insurance information.

Monthly Records: Each week, the coded language (in the form of a small paper tape) is sent to the processing center (Peat, Marwick, Mitchell & Co.) where the information in the tape is converted to punched cards, familiar clerical aids in many fields.

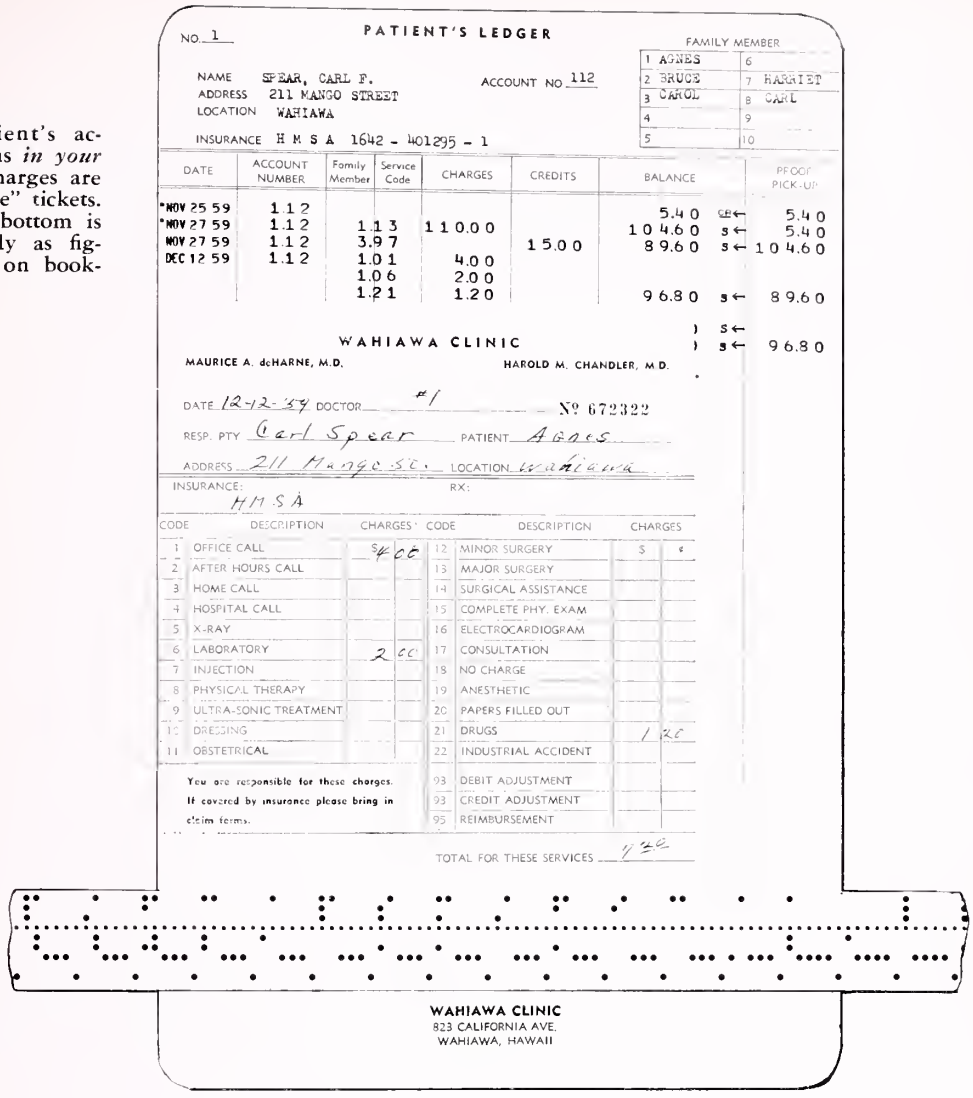
The punched cards are then used to produce the following monthly records:

- Complete itemized statements for all active accounts with charges and payments explained in full. Family members are also identified.
- Report of all active insurance claims. HMSA claim forms will be returned to the doctor's office completed, except for medical diagnosis and the doctor's signature.
- A 30-, 60-, and 90-day analysis of accounts receivable.
- A listing of cash receipts, broken down by days and source of income.
- A listing of professional services rendered and total charges of each service.

This tape punching machine is connected to NCR Bookkeeping Machine. Tape is sent to processing center where monthly statements, insurance reports and analyses are prepared.



Up-to-date patient's account card remains *in your own office.* All charges are recorded from "fee" tickets. Punched tape at bottom is made automatically as figures are posted on bookkeeping machine.



NO. 1

PATIENT'S LEDGER

NAME SPEAR, CARL F.
ADDRESS 211 MANGO STREET
LOCATION WAHIAWA
ACCOUNT NO. 112
INSURANCE H M S A 1642 - 401295 - 1

FAMILY MEMBER

1	AGNES	6	
2	BRUCE	7	HARRIET
3	CAROL	8	CARL
4		9	
5		10	

DATE	ACCOUNT NUMBER	Family Member	Service Code	CHARGES	CREDITS	BALANCE		PROOF PICK-UP
NOV 25 59	112					5.40	CF←	5.40
NOV 27 59	112	1	13	100.00		104.60	S←	5.40
NOV 27 59	112	3	97		15.00	89.60	S←	104.60
DEC 12 59	112	1	01	4.00				
		1	06	2.00				
		1	21	1.20		96.80	S←	89.60
							S←	
							S←	96.80

WAHIAWA CLINIC

MAURICE A. deHARNE, M.D. HAROLD M. CHANDLER, M.D.

DATE 12-12-59 DOCTOR #1 № 672322
RESP. PTY Carl Spear PATIENT Agnes
ADDRESS 211 Mango St. LOCATION Wahiawa
INSURANCE: HMSA RX:

CODE	DESCRIPTION	CHARGES $	¢	CODE	DESCRIPTION	CHARGES $	¢
1	OFFICE CALL	4	00	12	MINOR SURGERY		
2	AFTER HOURS CALL			13	MAJOR SURGERY		
3	HOME CALL			14	SURGICAL ASSISTANCE		
4	HOSPITAL CALL			15	COMPLETE PHY. EXAM		
5	X-RAY			16	ELECTROCARDIOGRAM		
6	LABORATORY	2	00	17	CONSULTATION		
7	INJECTION			18	NO CHARGE		
8	PHYSICAL THERAPY			19	ANESTHETIC		
9	ULTRA-SONIC TREATMENT			20	PAPERS FILLED OUT		
10	DRESSING			21	DRUGS	1	20
11	OBSTETRICAL			22	INDUSTRIAL ACCIDENT		
				93	DEBIT ADJUSTMENT		
				93	CREDIT ADJUSTMENT		
				95	REIMBURSEMENT		

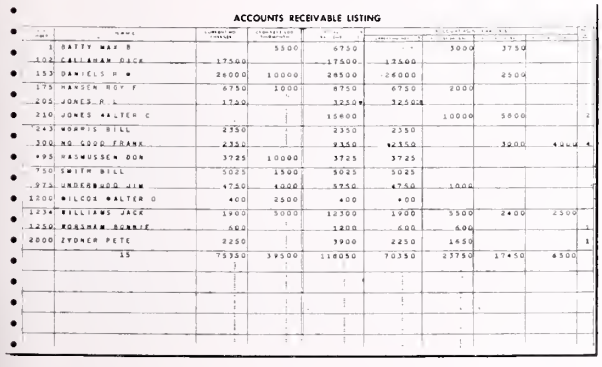
You are responsible for these charges. If covered by insurance please bring in claim forms.

TOTAL FOR THESE SERVICES 7 20

WAHIAWA CLINIC
823 CALIFORNIA AVE.
WAHIAWA, HAWAII

Cost of Processing: The processing of all reports, including insurance, averages 15¢ per account.

Analysis valuable:



ACCOUNTS RECEIVABLE LISTING

According to Drs. de Harne and Chandler, the analysis of accounts receivable prevents large past-due accounts receivable from building up because this is checked every month. As the result of intelligent use of this "analysis," collections have increased sufficiently to offset the cost of the equipment and the processing charges.

The new system has eliminated the need for a full-time bookkeeper in Wahiawa Clinic's office and allows the staff to devote more time to patients.

The value of this system to the medical profession can best be summed up in these words by Drs. de Harne and Chandler:

"We are thoroughly convinced that the benefits produced by machine bookkeeping methods are more than sufficient to justify their cost. Through the use of this system errors have been eliminated, a great deal of time has been saved by the elimination of statement preparation, and the patient has been made more aware of his financial obligation.

"One other important benefit is that we now have a detailed, up-to-date picture of the condition of our practice which was unavailable before.

"The peace of mind this has brought is at least as important as any of the tangible benefits produced."

R. M. KENNEDY
Executive Secretary

Infant Death Case Study No. 6

This 17-day-old male infant had been delivered spontaneously to a 30-year-old part-Hawaiian woman after 38 weeks of an apparently uneventful gestation. The mother had had eight previous deliveries with no recorded difficulty. She had received one injection of penicillin-streptomycin for bronchopneumonia. Two hours prior to the delivery, she had had a single watery stool. The infant was born after three hours of labor.

A ten-year-old brother subsequently admitted to the hospital with fever and diarrhea had negative stool cultures.

The infant weighed 7 pounds 13 ounces at birth and had a seemingly normal neonatal course. He accepted an evaporated milk formula readily. At five days, he developed an explosive diarrhea with 21 liquid stools in 24 hours. His temperature rose to 102° F. rectally; his weight dropped from 7 pounds 11 ounces to 7 pounds 6½ ounces. Terramycin 125 mg was given every four hours by mouth and 125 mg by "hypo" twice a day. Skim milk feedings were offered. On the second day of illness, he weighed 6 pounds 14 ounces. A hypodermoclysis of saline (unstated amount) was administered. He also received 0.5 cc of vitamin B_{12} and two cc of "complex." By the third day of illness he weighed 6 pounds 8½ ounces; skim milk feedings were discontinued and 5 per cent glucose water substituted over the subsequent 48 hours; Salmonella Group B was reported from stool cultures submitted the first day of illness to the State Department of Health. On the fifth day of illness, skim milk feedings were restarted. The infant then weighed 6 pounds 8 ounces. By the tenth day of illness the baby's condition was considered to be such that an increase in food could be tolerated and SMA formula was begun. Since he had been afebrile for 72 hours, the Terramycin was discontinued. Stools at that time averaged four per 24 hours. On the twelfth day of illness (the 17th day of life) the infant's weight dropped to 6 pounds 1 ounce. He suddenly became cyanotic and died en route to another hospital. The family refused a post-mortem examination.

Discussion

Infection within the newborn period can be insidious wherein the baby does not "do well" or terrifyingly sudden in onset, as in this instance. The explosive onset of watery stools and temperature elevation clearly indicated to the attending staff an acute bacterial enteric infection, as evidenced by the initial therapy. The selection of Terramycin as the antimicrobial of choice was logical in view of its reported effectiveness against some of the organisms responsible for newborn diarrhea (E. coli, Aerobacter aerogenes, Shigella). The dosage (approximately 185 mg per kilogram) was ample. The enteric infection appeared to respond to this therapy as indicated by the decreased number of stools and the return of temperature to normal. However, Terramycin is a bacteriostatic agent and in this instance may have suppressed the organism during its administration only to have it flare up following discontinuation of therapy. Moreover, it is considered only slightly effective against Salmonella organisms. The report of isolation of Salmonella should have prompted a change to Chloromycetin, the recognized antimicrobial of choice in salmonellosis.

A major aspect in the therapy of diarrhea of the newborn is the control of electrolyte and water loss. Within 48 hours from the onset of illness, this infant had lost 13 ounces or 10 per cent of his body weight. In 72 hours he lost 19 ounces or 16 per cent of his body weight. He should, therefore, have been considered in a state of severe dehydration, in spite of the apparent response of the diarrhea to antimicrobials. It is unfortunate that serum electrolyte levels were not determined and intravenous fluids were not administered to compensate for his loss of electrolytes and water.

The abrupt lapse of this infant into a shock-like state proceeding to death is common in Salmonella infections, due probably to the effect of the toxins and the loss of electrolytes and water. Since relatively small losses of electrolytes and water in a newborn infant can be disastrous, early transfer to hospitals where micro-determination of serum electrolytes can be made should become routine.

Classification: Pediatric, preventable, due to physician error in judgment and lack of proper hospital facilities.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

Protection from National Compulsory Insurance

O. D. PINKERTON, M.D., Honolulu

Support
Prepaid Medical Plans

Insure Your Plan's Success

Save $855,523.00

Increase Dues Income

PREPAID MEDICAL PLANS are here to stay unless they are knocked out by national health insurance—a fertile field for vote getting by socialist and liberal politicians. It should be obvious, even to those who oppose it, that the voluntary prepaid health plans, without question, have been the greatest single deterrent to compulsory state and national health insurance. The charitable efforts of individual physicians for the care of the indigent without cost, and the guarantee of care for any individual who needs it, have generally gone unheeded by the public and the politicians who serve them.

Savings Resulting from Reducing Medical Benefits by One Visit Per Case and Hospital Benefits by One Case Per 1,000 Members and One Day Per Case (1959 Experience)

	Amount of Savings	*Per Cent of Total Dues Income*
I. Effect of a Reduction of One Medical Visit Per Illness:		
Home and Office Care	$548,055	8.2%
II. Effect of a Reduction of One Hospital Day Per Case:		
Hospital Benefits	$277,585	4.1%
Physician Hospital Visits	23,181	0.3
Total	$300,766	4.4%
III. Effect of a Reduction of One Medical Hospital Case Per 1,000 Members Per Year:		
Hospital Benefits	$ 5,712	0.1%
Physician Visits	990	....
Total	$ 6,702	0.1%
IV. Discretionary use of x-ray laboratory benefits would affect savings; however, the amount of savings is hard to estimate.		
V. Summary:		
Medical Benefits	$572,226	8.6%
Hospital Benefits	283,297	4.2
Total	$855,523	12.8%

The general philosophy of state and federal politicians, along with general public moral deterioration, is not what is beneficial to our system of free enterprise, but what the politician can do to assure himself of re-election to office. The clamor continues for state control of a profession whose position today is high because it has remained free. The sooner medical men realize that there is a determined drive in progress to make them vassals of the state, the more determined they will become to support voluntary prepaid insurance plans.

The most vital problem today is how the costs of prepayment medical plans can be kept within the budget of the paying public. If the costs are not stabilized, the public may have to discontinue or curtail coverage and the inevitable result would be more charitable services performed by physicians, and increased clamor for federal control and expenditure by a government which is practically insolvent in spite of the present confiscatory tax.

It behooves physicians and patients alike to be cognizant of these costs and exercise discretion in the usage of medical plan benefits. The usage of hospital and medical benefits, especially those utilized in physicians' offices, can be dramatically reduced by careful attention of physician and patient.

The following statistics were obtained from the Hawaii Medical Service Association (HMSA), and were most startling to the author. It is certain that they will startle other members of the profession.

Stop and consider how much more would accrue to physicians, hospitals, and the member, or how much less the member would have to pay for his current HMSA medical plan, if such savings were realized. This is particularly true now that the Federal Employees Health Benefits Act has been

(Continued on page 570)

ADVERTISEMENT

182,000 have voted for free choice of doctor and hospital...



As of May 1, 182,000 members in Hawaii had voted for HMSA to be *their* plan.

"Voted?" you ask.

Yes, in a very real sense. These people not only have chosen HMSA plans to help pay the cost of illness, but are paying for this protection. It indicates an overwhelming preference of Hawaii's people for the sound, voluntary, prepayment medical plans offered by HMSA. It indicates that HMSA is doing the job for which it was created, and is providing services on a basis that is mutually satisfactory to its members, to the medical profession, and to the employers of Hawaii.

At a time when the problem of paying for adequate medical care for the aged is becoming a white hot political issue in Washington, it becomes even more important than ever for a voluntary prepaid medical plan to do its job.

182,000 members in Hawaii say that we are.

Blue Shield Plan for Hawaii

HMSA ®

HAWAII MEDICAL SERVICE ASSOCIATION

Member, Western Conference of Prepaid Medical Service Plans

1154 Bishop Street / Honolulu, Hawaii / Phone 66-151

Branches: Hilo • Wailuku • Lihue

This is What's New!

Conn's suggestion that the mysterious disease **familial periodic paralysis** is actually intermittent aldosteronism is not borne out by a study recently completed at the N.I.H. Although the urine **aldosterone** level did **not increase** before attacks, the authors did corroborate Conn's conclusion that a **low sodium diet** is probably better therapy than the traditional high potassium diet. (*Am. J. Med.* [Mar.] 1960.)

Chaikoff reports an increased percentage of **thyroid cancer** following I^{131} administration to a thyroid cancer strain of rats. Starr in *Cancer Research,* which appeared about the same time, reports **complete failure** to induce thyroid carcinoma in the same high thyroid cancer strain by **larger** doses of I^{131}. (*A.M.A. Arch. Path.* [Mar.] 1960.)

The correlation between the thickness of the ventricular wall and the electrocardiogram is rather high in **left ventricular hypertrophy,** where the EKG diagnosis of LVH is anatomically **correct** 75 per cent of the time. The EKG diagnosis of **right** ventricular hypertrophy is more difficult, with a poorer anatomical correlation than in the case of LVH. **Combined** ventricular hypertrophy, with both RVH and LVH, is usually **missed** in the electrocardiogram with the EKG diagnosis having been made in only **10 to 20 per cent** of the cases proved at autopsy. (*Circulation* [Feb.] 1960.)

A California general practitioner, apparently annoyed at his lack of new knowledge after another **"psychiatry in general practice"** seminar, has his sharp criticisms outlined in the lead article of a psychiatric journal. Samples: "If psychodynamics cannot be explained in a lecture series, please stop inviting us to attend." "We are not medical students. Try talking over our heads on occasions." (*A.M.A. Arch. Gen. Psych.* [Mar.] 1960.)

By the use of intravenous **radioiodine-labeled Diodrast,** a rough estimate of the **cerebral flow to the two hemispheres** can be made. This requires continuous recordings of two scintillating collimators, one on each side of the head. This procedure supplements and in some instances may obviate cerebral angiography. (*Neurology* [Mar.] 1960.)

In Philadelphia, pediatrician Stokes advised passive-active **immunization** against **viral hepatitis** by a very small dose of gamma globulin, 0.01 ml/pound body weight of **cold-ethanol fractionated gamma globulin.** This does not produce serum hepatitis but protects almost all exposed susceptible persons against the more severe symptoms of epidemic hepatitis. Trial immunizations against epidemic hepatitis in closed institutions is suggested. (*J.A.M.A.* [Feb. 13] 1960.)

The problem of **shark attacks** the world over is summarized in a book by an Australian, V. M. Coppleson. In spite of watchtowers, airplane patrols, explosives, shark repellent powders, and so on, off one South African beach, there were 35 shark attacks in ten years. Finally, the authorities protected the beach area by two miles of **underwater netting.** After four years, 1,200 sharks have been captured and no shark attacks recorded (*Shark Attack,* V. M. Coppleson, 1958.)

Hepatic coma has recently been treated by **total colectomy** and ileorectal anastomosis. The patient was a 63-year-old housewife who had had 40 episodes of hepatic stupor and coma during the five years prior to operation. A colectomy was performed on the presumption that the cerebral symptoms result from the influence of various nitrogenous substances on the brain. These substances are believed formed by bacterial action on protein within the colon. However right the theory, the patient has had no further episodes of hepatic coma or stupor after this rather drastic procedure. (*Lancet* [Feb. 27] 1960.)

Pain and tingling of the hands during pregnancy are fairly common symptoms, often attributed to various metabolic changes as well as hyperventilation. However in 14 pregnant patients, the compression of the median nerve as part of the **carpal tunnel syndrome** was the cause of the symptoms. Most patients **recovered spontaneously after delivery.** Fluid retention during the last trimester was felt to be the main causative factor. In another series reported in the same journal, 25 nonpregnant patients with median-nerve compression received an **injection of hydrocortisone into the carpal tunnel.** Twenty of the patients had prompt symptomatic relief. (*Lancet* [Feb. 27] 1960.)

FRED I. GILBERT, JR., M.D.

In Memoriam -- Doctors of Hawaii -- XXVI

This is the twenty-sixth installment of In Memoriam—Doctors of Hawaii.

John Christopher O'Day

John Christopher O'Day was born in Dunkirk, New York, on December 10, 1866.

As a youth in Pennsylvania, Dr. O'Day was successively a messenger boy, telegrapher, railroad fireman, train dispatcher, and a student of mechanical engineering.



DR. O'DAY

His start toward medicine came when he was called upon to act as an assistant to a surgeon in an emergency operation. Doctors urged him to take up medicine. This looked impossible but with wise prodding from his medical friends, young O'Day received his first medical degree in 1896 from the National Normal University College of Medicine at Lebanon, Ohio, and a second from Northwestern Medical School in 1900.

A knowledge of oil wells, gained from long connection with the Standard Oil Company as a trusted scout, enabled him to make a lucky investment. He struck a gusher and financially was a made man.

Then followed more study in England, Scotland, and Germany.

On November 11, 1901, Dr. O'Day married Lamanda Felicia Shearman at Jamestown, New York. The couple had two daughters, Celia and Nina (Mrs. Walter McManus).

Dr. O'Day practiced both in Pennsylvania and Oregon.

In 1906 Dr. O'Day came to Honolulu as a tourist. He arrived here from New York, N. Y., with his family, by way of Cape Horn. He loved the life and the people in the Islands so much that he practiced here until 1912. He then left the Islands to go to Portland, Oregon, where he studied goiter surgery under Dr. Robert Coffey. In the spring of 1917, he returned to Honolulu to make it his permanent home.

Dr. O'Day was physician to Queen Liliuokalani in the closing years of her life. He was the only attending physician at the death of Prince Jonah Kuhio Kalanianaole, Delegate from the Territory of Hawaii.

Dr. O'Day gained world-wide acclaim for devising two surgical operations. One was for stomach surgery in which a new valve is created to take the place of that removed when a stomach cancer or ulcer adjoining the valve in the lower part of the stomach is removed. It is the only operation of its kind that conserves the detailed functioning of the stomach after removal of either an ulcer or cancerous growth. The operation is known in the surgical world as O'Day's damper gastrojejunostomy. The technique was first brought out by the official organ of the American College of Surgeons, of which Dr. O'Day was a Class A Fellow.

The other operation is for the treatment of a bladder condition and the feature of it is the character of the stitch.

In 1905, Dr. O'Day wrote "Oil Wells in the Woods," dealing with the folklore in the oil fields of Pennsylvania.

From 1915 Dr. O'Day fought against what he called "the unionizing of doctors" by the American Medical Association and similar organizations. He summed up his views in a book entitled "A Portrait of Two Doctors," published in 1940 and which resulted in national comment. In this book Dr. O'Day claimed the medical profession is controlled more by politics than by science.

In addition to these two books, Dr. O'Day wrote many articles for medical and other scientific journals.

Dr. O'Day died on July 2, 1945, in Honolulu at the age of 78.

Harvey Lee Ross

Harvey Lee Ross was born November 12, 1880, at Mayfield, California, the son of Joseph and Louise (Bacon) Ross. He was a direct descendant of Richard Henry Lee, author of the resolution in Congress, June 7, 1776, declaring that the colonies should be free and independent states, which paved the way for the Declaration of Independence adopted 27 days later. His grandfather was Harvey Lee Ross, an early and noted pioneer of Illinois and an intimate friend of Abraham Lincoln and Andrew Jackson.

He was educated at Macomb (Illinois) High School, graduating in 1898. Cooper Medical School, San Francisco, granted him his M.D. in 1903. Dr. Ross interned at Lane Hospital in 1903 and at French Hospital in 1905, both in San Francisco. Shortly afterwards he came to the Islands.

On May 2, 1907, Dr. Ross married Ethel Ada Rickard at Laupahoehoe, Hawaii. Their one son, Alexander Treloar, graduated from the University of Oregon Medical School and is now Professor of Neurology and Chairman of the Department of Neurology, University of Indiana Medical School.

Dr. Ross served as government physician for the South Kohala district, Hawaii, from 1906 to 1910, making his home at Waimea.

From 1910 to 1912 he was ship's surgeon aboard the Matson liner S.S. "Wilhelmina."

Following his two years at sea, Dr. Ross was appointed government physician for the South Kona district of Hawaii, which position he held until 1917. At one time he was superintendent of the Kona Hospital.

At the outbreak of World War I, the family moved to Honolulu. During the war, Dr. Ross served as a captain in the Army Medical Corps.

At the close of the war, he was connected with the Territorial Board of Health, having charge of the medical division of government schools and doing much work in the anti-tuberculosis bureau.

Dr. Ross died September 27, 1921, at Waialua, Oahu, within a few months of his 41st birthday.

He was a member of the Territorial Medical Society and the Association of Military Surgeons of the U. S. and a charter member of Upsilon chapter of Nu Sigma Nu fraternity.

Book Reviews

Current Medical References

Edited by Paul J. Sanazaro, M.D., 535 pp., $3.50, Lange Medical Publications, 1959.

This is an excellent source handbook of medical references. Despite its compactness its contents are quite comprehensive. References cited should lead one to further works, since articles mentioned include generous bibliographies. References were selected with this view in mind and to their general availability. Of interest as a sidelight is the inclusion of references to problems such as dry skin and insomnia.

BERNARD J. B. YIM, M.D.

Method of Anatomy, 6th Ed.

By J. C. Boileau Grant, M.C., M.B., 879 pages, $11.00, Williams & Wilkins Co., 1958.

This is a text book of regional anatomy, well illustrated by simple black and white line drawings. It is an excellent dissection manual. It makes study of anatomy interesting and is an excellent book for students. It covers the whole subject of anatomy by regions.

KENNETH M. AMLIN, M.D.

★Manual of Skin Diseases

By Gordon C. Sauer, M.D., 269 pp., $9.75, J. B. Lippincott Co., 1959.

This generously illustrated, concise, practical textbook of dermatology is aimed at the general practitioner, pediatrician and internist. For them it would be a most useful desk-top reference book. There are numerous tabulations and charts of diagnostic clues and guides. The photographs, many of which are in color, are for the most part very good though the big colored picture of a chancre seems clearly to be a chancroid, presumably with a chancre in it.

There are a few curious statements to which exception could be taken. Keloids are said to be hypertrophic scars; of course they are more than this, and some effort to distinguish them should be made. Purpura is defined as "a large petechial lesion," and the group of diseases (which it actually is) are not well presented. Anaphylactoid purpura is not mentioned except in the combination glossary and index, where it appears as "Schönlein's purpura, thought to be related to Henoch's purpura." The statement that "no two skin diseases look alike" would be difficult or impossible to defend.

No recognition is given to chronic or even mild systemic LE; this is described only as "acute disseminated LE" with a positive LE test. Steroids receive—probably wisely, in a book for non-dermatologists—very scant mention: they are advised for severe protracted alopecia areata, resistant exfoliative dermatitis, severe dermatitis venenata or erythema multiforme, and, questionably, as the first thing to use in acute disseminated LE. The chart of psoriasis mysteriously fails to indicate the frequent involvement of the frontal scalpmargin, the genitalia, the umbilicus and the shins. Under the lepromin test, it is said, mysteriously, that "false positive reactions do occur."

These criticisms are not serious ones. This is a valuable and eminently practical manual of practical office dermatology, and it is highly recommended.

HARRY L. ARNOLD, JR., M.D.

★ means highly recommended.

★The Care of Minor Hand Injuries

By Adrian E. Flatt, M.A., M.D., F.R.C.S., 266 pp., $9.50, The C. V. Mosby Co., 1959.

In publishing this book, Adrian Flatt has fulfilled a need for the general practitioners and specialists alike in emphasizing the importance of adequate care of the injuries we see daily in the office as well as in the hospital. It is excellently written, well organized, and correlates nicely the injury with the pathology and logical treatment, emphasizing the details which are so important in proper preventive as well as definitive therapy of a most frequent injury, which, neglected, causes considerable disability.

The book is to be recommended highly for the library of every active practicing physician, particularly those who see a large volume of industrial hand injuries.

IVAR J. LARSEN, M.D.

Anatomy for Surgeons, Vol. III

By W. Henry Hollinshead, Ph.D., 901 pp., $23.50, Paul B. Hoeber, Inc., 1959.

At first glance this volume does not impress the reader as being adequately oriented to the field of surgery. However, continued reading, which is surprisingly easy for such an erudite treatise, demonstrates a thorough coordination of basic anatomy with surgical application. There are numerous references to the latest physiological, endocrinological, pathological, and experimental works as they apply to surgical principles.

The illustrations, unfortunately, are insufficient to edit this work on a par with the detailed writing. They combine schematic representation with classical reproductions.

I believe that this book would be a valuable addition to any surgeon's library and represents a classic in its field.

KEITH KUHLMAN, M.D.

★The Writing Road to Reading

A Modern Method of Phonics for Teaching Children to Read

By Romalda Bishop Spalding with Walter T. Spalding, 238 p.p, $4.00, published by Whiteside Inc. and William Morrow & Co., 1957.

Many people today have children who suffer from "specific language disability." They are intelligent children but have difficulty with spelling, reading, and writing. The following summary defines the objectives of the unified phonics method as "to help prevent the unhappiness in the appalling loss caused by so large a proportion of our people living and thinking, working and producing, at levels, so far below their inborn mental abilities, because of their relative inability to read and write."

The book was developed over a period of years from the wide teaching experience of Mrs. Spalding in many different schools. She realized that many of the different methods used in schools, particularly the so-called "look-say" method was leaving an increasing number of students with an inability to read and write properly. This book attempts to teach teachers and parents this new method of phonics and how to apply it. Because of the

(Continued on page 584)

Notes and News

Coming Events

Dr. Walter Quisenberry will address the New York Academy of Sciences in June. He will speak on the subject of socio-cultural factors in cancers.

A dinner honoring **Dr. Max Levine** will be held in July at Tripler Army Hospital. Further details will be published in the HMA monthly Newsletter.

Muscle Men

Drs. Richard K. C. Lee and **L. Clagett Beck** handled arrangements for a clinic presented by **Dr. Thomas K. Cureton** of the University of Illinois. This clinic demonstrated that a number of local physicians, including **Drs. Richard Sakimoto** and **James Harrison,** should consult their family physicians for a thorough physical examination.

Speeches and Meetings

Dr. William J. Holmes addressed the Pan American Association of Ophthalmology in Caracas, Venezuela. The considerable efforts of the Honolulu County Medical Society, together with the *Advertiser,* in public education were advanced by **Drs. Unoji Goto, Scott Brainard, L. T. Chun,** and **A. S. Hartwell.** They discussed heart disease at a recent public forum. **Drs. Louise S. Childs, Donald C. Marshall, Dorothy S. Natsui,** and **Thomas Y. K. Chang** participated in another panel on teen-age problems. **Dr. Claude C. Caver** moderated both forums.

Students

Drs. Shigeru R. Horio, Hasting H. Walker, Raymond DeHay, and **Norman R. Sloan** attended the recent American College of Physicians' meeting in San Francisco.

Happy Events

Dr. and Mrs. Samuel Wallis of Lihue, Kauai, celebrated their 20th wedding anniversary on April 2. **Dr. and Mrs. K. H. Dung** are the happy parents of a new son, Robert.

Competition

Fourteen new medical licenses were recently granted to **John R. Watson, Billie F. Strother, Seigne Talbot, Erida Reichert, Paul E. Poenisch, James L. Lynde, Ross Y. Hagino, John F. Hanley, Francis Fukunaga, Richard M. Fardal, Anne Marie Brault, David Kliewer, William J. P. Cody,** and **Victor S. Dizon.**

New Offices

Drs. Richard Lam, Raymond Kong, Patrick Lai, Gail G. L. Li, Warren Wong, Min Hin Li, and **George F. Schnack** have new offices at 1525 Kalakaua Avenue. **Dr. Kwong Yen Lum** is now located at the Central Medical Building. The Kaimuki office of the Medical Group and **Dr. E. W. Haertig** have moved into the new Waialae-Kahala Medical Building.

Honors

Dr. Min Hin Li received the North Dakota Governor's Flag. **Dr. C. M. Burgess** won the Smithsonian award for his Hawaiian Shell Display at the Annual Seashell and Marine Life Exposition. **Dr. Clarence Fronk** was named a member of the City Parks Board.

Request

The JOURNAL would appreciate receiving any tidbits of gossip (scandalous or otherwise) which would serve to make this column more interesting. Please telephone items to Lee McCaslin, 57-907, Hawaii Medical Association.

8th CONGRESS

Pan-Pacific Surgical Association

September 27–October 5, 1960

Headquarters—Princess Kaiulani Hotel

County Society Reports

Hawaii

The February (1960) meeting of the Hawaii County Medical Society was held on February 19 at the Hukilau Restaurant. Guests present were Dr. Albert Dorfman, Professor of Pediatrics at the University of Chicago School of Medicine, and W. Mayer.

The coming Forand Bill legislation was mentioned, and each one was urged to express his view to the local congressmen.

Reference was made to the reception luau on February 25 at the Hale Nani in honor of Mr. Basil O'Connor of the National Foundation. Members were urged to attend the luau. A motion was made by Dr. Loo, and seconded by Dr. Miyamoto, to send the Chairman of the Polio Committee to the luau at the expense of the Medical Society. The motion was carried.

Following the business session, Dr. Dorfman gave a talk on rheumatic fever. He emphasized the importance of making an accurate diagnosis of the disease, in order not to subject a nonrheumatic child to many months of needless bed rest. He also discussed recent trends in the treatment of the disease and the prevention of its recurrence.

* * *

The March meeting of the Hawaii County Medical Society was held on the 11th at the Hilo Hotel. The Society was host to a group of doctors on the Committee on Maternal and Child Health. Arriving from Honolulu were: Dr. and Mrs. Clarence Wyatt, Dr. Satoru Nishijima, Dr. Grant Stemmerman, Dr. and Mrs. Jack Woodruff, Dr. H. E. Bowles, Col. John P. Fairchild, M.C., Col. Edward A. Zimmermann, M.C., Dr. Frances Nakamura and Dr. K. J. Edgar. Guests at the meeting were seven nurses from the obstetrical department of the Hilo Memorial Hospital and Dr. Davis, Sr., from Minnesota.

The meeting was called to order by the President, Dr. Richard Hata, at 7:30 P.M. He requested that the doctors turn in the questionnaire on the television program as soon as possible to the Hawaii Medical Association.

Following the business session, the meeting was turned over to Dr. Clarence Wyatt, Chairman of the Committee on Maternal and Child Health. He introduced each doctor on the panel who spoke on some phase of eclampsia, pre-eclampsia, and prematurity.

TOKUSO TANIGUCHI, M.D.
Secretary

Honolulu

The Honolulu County Medical Society met on Tuesday, January 5, 1960. Mr. George Kellerman, President of Bishop Securities Ltd., spoke on "Securities for Profit and Retirement Income."

President H. Q. Pang called the meeting to order at 8:40 P.M. with 71 members present.

New members introduced by President Pang were Dr. Noboru Oishi and Dr. Samuel Buist. Dr. Robert J. Emrick was not present.

Copies of 1960 Budget were distributed through the mail and were made available at the meeting.

Dr. West pointed out that the appropriation for the Legislative Committee was not included. Mr. Kennedy stated that there is a sum of about $250 in the savings account. Miss McCaslin stated that the HMA $1,000 budget for 1959 was not used, therefore reverted back to the general fund. Council and delegate action was necessary for reappropriating the money for Legislative committee work which would be in May.

Dr. West moved that the Board of Governors investigate need for funds for the Legislative Committee and make necessary appropriation. Motion was seconded and carried.

A motion that the Budget as circulated be approved was made by Dr. West, seconded and carried.

Mr. Richard Kennedy explained how discussion and study of Public Law 86-382 came about in the Society. This matter was called to the attention of the Board of Governors by our Representative to HMSA. The Board after hearing the report referred the matter to the Medical Care Plans Committee. This committee met with the HMA's Federal Medical Service Plans Committee (statewide matter) and representatives of HMSA on January 3. This joint committee recommended that two M.D.'s be sent to Washington, D. C., to negotiate in the best interest of the doctors.

Mr. Kennedy reported that this morning a telephone conference was held with the head of the Federal Civil Service Commission by Drs. Nishigaya, H. Q. Pang, O. D. Pinkerton, C. C. McCorriston and E. F. Cushnie and A. Yuen, R. M. Kennedy and Lee McCaslin. The conference result was that the area of concern can be handled through the mail. An extension of deadline for filing for certification was granted.

Mr. Yuen discussed the types of plans formulated to be offered to the federal employees.

1. Government-wide Service Plan (Blue Shield-Blue Cross)
2. Government-wide Indemnity Plan (Aetna)
3. Employee organization plan (ex-postal workers in Washington, D.C.)
4. Comprehensive Plans
   (a) Group Practice (Kaiser)
   (b) Individual Pre-payment (GHI)

Plans 1, 2 & 4 will be offered locally. Mr. Yuen described in detail what each plan entailed and the problems encountered by the doctors in Hawaii. Question and answer period followed.

Copies of the Fee Adjustment Committee proposed changes in HMSA Fee Schedule were circulated. Dr. Reppun distributed copies and spoke on several changes in the schedule. A discussion period was held.

Dr. R. D. Moore moved that Dr. Reppun's proposal be referred to the Fee Adjustment Committee. Motion was seconded and carried.

Dr. M. Berk moved that the Fee Adjustment Committee's proposed changes as circulated be accepted. Motion was seconded and carried.

Dr. Ando pointed out that according to the Bylaws the dues for the new year are set at the last membership meeting of the preceding administration. Dr. Ando moved that the dues for 1960 be $105.00 and the breakdown be the same as 1959. Motion was seconded and carried.

Meeting was adjourned at 10:58 P.M.

* * *

The Honolulu County Medical Society met on Tuesday, February 2, 1960. A timely subject entitled "The Donkey, The Elephant, and You" was discussed by

(Continued on page 570)

Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING
March 4, 1960, at 7:30 P.M.
Wailuku Hotel, Maui

PRESENT

Dr. Toru Nishigaya, presiding; Drs. Allison, Bergin, Burden, Goodhue, Spencer, and members of the Maui County Medical Society.

MINUTES

The minutes of the November 18, 1959, meeting were approved as published.

FEDERAL EMPLOYEES HEALTH BENEFITS ACT

Dr. Nishigaya spoke briefly on the negotiations that were going on between the HMSA and the Civil Service Commission. He recounted the action that had taken place at a special meeting of the Honolulu County Medical Society on February 23 and at their regular meeting on March 1. He told of a cable that was subsequently received from Washington which reversed an earlier ruling and stated that the first home or office calls could not be deductible and so HMSA had to change the premium structure to comply with this ruling. He discussed the participating physician's agreement and showed the members a copy of the form which has to be signed and returned to the HMSA by March 11. He mentioned that there is one feature which will probably meet with disapproval and that is the publication of a list of participating physicians, which is required.

Dr. Wong said that in view of the action taken at a previous meeting, it was incumbent upon Maui to go along with whatever Honolulu County wishes to do. Some of the Maui doctors disagreed. Dr. Nishigaya explained that the resolution that was passed by Honolulu County was proposed in order that the individual doctors would participate under 4 (4-b) if they so wished; the plan was not accepted by the Society.

DOCTORS' CONTRIBUTIONS

A letter from Dr. O. D. Pinkerton dated January 14 was read in which he suggested that the medical profession be sent a questionnaire to determine the number of hours they contribute yearly to the indigent and the medically indigent patients. Dr. Burden said the indigent patients were taken care of by government physicians on Maui. Drs. Goodhue and Bergin said it was the same on their islands. Dr. Cushnie didn't feel such a survey would be accurate. Dr. Burden spoke of his experience as government physician and said they got about $13.00 quarterly for medicines which cost him about $50.00 a month. Dr. Bergin thought we should find out more about what Dr. Pinkerton had in mind; should we find out how much the doctors do for nothing or how much indigent care do they perform. Dr. Allison thought that if we embark in this, we should get the help of statistical experts.

ACTION:

It was voted that the idea is a good one and should be referred to the Honolulu County Medical Society's Board of Governors for their consideration.

ROSTER

A letter from the Board of Medical Examiners dated December 7, 1959, stated that since the Hawaiian Telephone Company lists all physicians under their specialty, the members of the Board could not see the necessity of going to the expense of having such a manual printed. A discussion followed on the propriety of the Yellow Book listings and it was concluded that publishing a roster would not solve the problem of proper listings.

ACTION:

It was voted to drop the idea of publishing a roster.

ANNUAL MEETING

Dr. Nishigaya gave a brief report on the progress of the Scientific Program and Arrangements Committees.

HEALTH EDUCATION COMMITTEE

Dr. Allison was asked to discuss the problems of the Health Education Committee. He was asked if the matter of having the programs sponsored had ever been considered and he advised that this had come up from time to time but such an arrangement had not been considered advisable. The matter of using video tape was discussed at some length. The neighbor island doctors did not feel the committee should plan to send the tapes to them.

ACTION:

It was voted that the use of video tape be approved for one year and that the Health Education Committee work out the best system of implementing the program and be authorized to use their judgment as to the best manner of procuring and utilizing the tapes.

SALARIES AND PERSONNEL

The *ad hoc* committee report recommended that the executive secretary's annual salary should start at $8,400.00 as of last January, and that no top figure be listed at this time; that the stenographer's monthly salary should have a range of from $250.00 to $385.00; and that the casual part-time help should be paid from $1.00 to $1.25 an hour; that one-third of the salaries of the executive secretary and the stenographer should be charged to the JOURNAL; that the executive offices operate on a five-day week with hours from eight to five and one hour for lunch. No overtime is paid to the stenographer (unless over the legal limit). The offices are closed on all State holidays as listed by the Chamber of Commerce. A Christmas bonus of 2% of the annual earnings is paid to all employees in the employ of the Association on the 24th of December. The annual vacation for all monthly employees is three weeks with pay after one full year of employment and if a holiday falls during the vacation period, this day is added to the three-week period.

The Council voted on the salary recommendations one by one. The salary of the executive secretary was discussed in detail. It was felt that a committee should work out an annual increment.

ACTION:

It was voted to accept the report of the ad hoc committee and that the same committee, or a new committee, be instructed to get together with the Honolulu County Medical Society to work out an equitable salary schedule and annual increment with the help of a consultant and to report their findings back to the Council.

(Continued on page 592)

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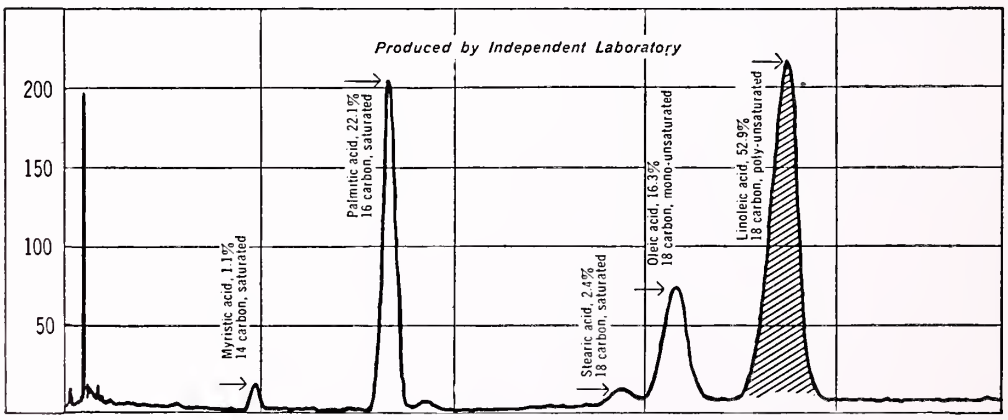
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Excerpted from J.A.M.A., Aug. 29, 1959

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

ROSIE CHANG, *Editor*

FLORA OZAKI, *Associate Editor*
KATSUKO ENOKI, *Associate Editor*
HAZEL KIM, *Associate Editor*
MILDRED KIM, *Associate Editor*

OLIVE C. PRIDGEN, *Executive Secretary*

President's Message



SISTER MAUREEN
President

Your State Nurses' Association has again indicated its interest in community needs by appointing a Committee on Geriatrics. Through this Committee your Association was represented at the State Conference on the Aging held May 6 and 7.

Our interest and support of our student nurses—our hope for the future—is now tangibly indicated by our co-sponsorship of Hawaii Student Nurses' Association with Hawaii League of Nursing. We commend our Hawaii League for sparking a successful workshop on recruitment in which Mrs. Helen Miller from National League of Nursing Headquarters participated. Student nurse representatives collaborated in the program, refreshing us once more with their enthusiasm and spontaneity.

Your President and President of Hawaii Student Nurses' Association, Marjorie Oda, travelled by jet to Miami for the National Convention of Student Nurses' Association and American Nurses' Association. A detour and stopover in New York City gave Marjorie an opportunity to see the Big City for the first time. Alison MacBride, Executive Secretary of Hawaii Board of Nurses, and your President were Hawaii's delegates to the Convention. They also attended the State Board Conference which preceded the Convention.

With pride in our professional organization, we are exhorted to an all-out effort to promote the current drive for funds for the American Nurses' Foundation. The slogan for each of us is:

Give or Get $5.00

Research is a growing concern and surely Hawaii's nurses will press forward to demonstrate their wholehearted support. We count on you.

Editorials

ANA Miami Meeting

May is an eventful month to nurses. The Biennial Convention of the American Nurses Association was held May 2-6 at Miami, Florida. Sister Maureen, President of Hawaii Nurses Association, and Alison MacBride, Executive Secretary of the Hawaii Board of Nursing attended.

We plan to include their reports in the next issue.

Mental Health Week

During Mental Health Week, May 1-7, there will again be a concerted drive to bring mental health to the public's attention. Nursing, like the other health professions, has in addition a special year-around responsibility for helping to raise the general level of mental health.

Florence Nightingale's Birthday

To many people Florence Nightingale represents the personification of nursing, the traditional "lady with the lamp." Those more familiar with her life and writings, however, recognize that her influence and interests extended far beyond the nursing field. She was not only the acknowledged authority on nursing and nursing education, but she was also an expert on hospitals and sanitation, a skilled statistician, and an influential figure in the political and social world of her day.

This year, 1960, is the 100th anniversary of the founding of modern nursing by Florence Nightingale. Nurses will be recognizing this historical event. On Oahu, a commemoration service was held at the Kawaiahao Church on Sunday, May 8. Military nurses, student nurses, and practical nurses attended this service at the Sheraton Meeting House in full uniform. A dinner was held on May 12 to pay tribute to Florence Nightingale, founder of modern nursing, and the community joined Oahu nurses in celebrating this occasion.

Executive Offices

Business of the Hawaii Nurses Association is carried on as usual while Mrs. Pridgen is attending the University of Hawaii. With the able help of Helen Ohara, Mrs. Mary Walsh is looking after the affairs of the Nurses Association. Mrs. Walsh has been inactive in nursing since resigning her position as Director of Nurses at Children's Hospital in 1957. However, she has always retained her interest in all things nursing and is a member of the Hawaii League for Nursing as well as Hawaii Nurses Association.

One of the more important items of business has been the launching of the Super Savings Stamp campaign to purchase air transportation in order that the President of Hawaii Nurses Association may attend the ANA Convention in Miami next May. The Association will be in need of books of Savings Stamps for the next few months—206 books are required.

General Interest

Dr. Ira Hiscock's Health Inventory

Dr. Ira Hiscock, Carnegie Visiting Professor in Public Health at the University of Hawaii, will inventory the health needs, services, and programs, of Hawaii for the fourth time. The third study, made in 1949-50, culminated in recommendations that set much of the course of public health programs.

The Public Health Committee of the Chamber of Commerce has made an appropriation of $2,000 to finance Dr. Hiscock's study, which will be coordinated by the Oahu Health Council.

Miss Virginia Jones, Dean of the College of Nursing, University of Hawaii, is the chairman for this study. The survey will be a self-study. The participating agencies will do self-evaluations and appraisals with Dr. Hiscock serving as the resource person.

Convention Notes

The 1960 convention site is the Island of Maui where the nurses are celebrating the silver anniversary of their district association. Definite convention dates are Thursday, Friday, and Saturday, October 20, 21, and 22, 1960.

The Kahului Armory is the site of the convention. Lunches will be served at the Armory. Tentative plans include a no host dinner for delegates arriving early on Wednesday, October 19, and two other evening affairs. One of the affairs will be held in a private home with Hawaiian entertainment being furnished. The other evening affair is the annual banquet night, featuring the silver anniversary charter members who have been in the Association for 25 years.

The general theme of the convention is "Security—what is it?" There are many examples of the different types of security which might be covered—economic, physical, spiritual, mental, etc. Suggestions for convention program sessions are being received by the Maui program members in care of Mrs. Elizabeth McCall, Kula Sanatorium, Waiakoa, Maui.

Economic Security Workshop

The need for a strong economic security program was brought out by last October's convention. Spurred to action was the Association's Economic Security Committee under the chairmanship of Kazue K. McLaren. The committee met twice, followed by an orientation session on the economic security program. Plans for an economic security workshop were subsequently approved by the Hawaii Nurses Association Board of Directors.

Tentative plans for the workshop include a kick-off dinner meeting on July 7, 1960, with the A.N.A. field person as keynote speaker. The workshop will be held on July 8 and 9. These two days will be divided into morning and afternoon unit sessions.

A registration fee of $2.00 for the entire workshop will be charged to defray expenses of printing and postage. For people interested in attending separate sessions, a fee of 50¢ for each of the four unit sessions will be charged.

The Association Board meeting will be held on July 7 in order that more members will be able to attend the workshop without incurring additional transportation costs. The workshop will be open to all nurses and practical nurses, irrespective of membership.

Miss Anne Kinnere

With profound regret, we note the death on March 4 of Queen's long-time employee, Anne Elizabeth Kinnere, 73. Miss Kinnere stayed with the hospital beyond her 1952 retirement, living at Harkness and working part-time as a good-will ambassador and trouble-shooter at the Hospital.

Tiny Miss Kinnere was born in Cleveland, Ohio, in 1886 and took her professional training at New Haven Hospital in Connecticut. In 1919 she visited Hawaii on a year's leave of absence from Yale Infirmary and fell in love with the islands. By chance she met Queen's Director of Nurses at a dinner party and was persuaded to accept a position here.

As a head nurse on Pauahi and Bishop 2 from 1920 to 1952, Miss Kinnere became an institution at Queen's. She showed a sincere interest and understanding in each patient and followed up their needs with meticulous care. Even now patients often ask to be placed on her floor and when she retired, her contribution to patients and to the nursing service was recognized in newspaper publicity.

Throughout her unbroken record of outstanding faithful service, Miss Kinnere was an inspiration to young nurses, always ready with an encouraging smile and the advice of experience.

Her attention to duty and warm genial personality won a host of friends for her and for Queen's, in which her loyalty and interest was deep and constant. Miss Kinnere suffered a heart attack while dressing for work. Services were held over her ashes on March 8. The family requested that in lieu of flowers, contributions be made in her memory to The Queen's Hospital Memorial Fund.

Air Force Nurse Corps Celebrates 11th Birthday

Now a firmly established part of the Air Force, the Nurse Corps is keeping in step with this Service's amazing technological advances. This year saw the opening of the new School of Aviation Medicine. This all-modern facility, located at Brook Air Force Base, San Antonio, Texas, is charged with training Flight nurses and is including in the curriculum current and research trends in Aerospace Medicine. The medical and nursing problems connected with flight in the age of air and space travel are unique, to say the least.

In addition to Flight Nurse Training, there are other educational and training program open to Air Force nurses. For example, each year groups are sent to leading universities to earn baccalaureate or masters' degrees in nursing administration and nursing education. Air Force nurses may also receive training in anesthesia, obstetrics, surgery and other nursing specialties.

After 12 months of service an Air Force nurse may volunteer for overseas duty. Countries such as France, Spain, England, Japan and others presently offer a variety of duty stations. Air Force hospitals vary in size, are modern, and adequately staffed with nursing service personnel.

Recently Colonel Dorothy N. Zeller assumed the office of Chief, United States Air Force Nurse Corps. She replaces Colonel Frances Lay, who was named Command Nurse, United States Air Force, Europe.

After eleven years of vigorous activity and growth, the Air Force Nurse Corps stands poised for a new decade of accomplishment. New problems will be encountered by the men of the Air Force as new air and space vehicles come into being. The medical and nursing techniques required to restore and maintain their health and well-being are now in the exploratory stages. Serving these men, their families, their country – . . . and themselves gives an Air Force nurse a real sense of professional fulfillment.

A legend has grown in the Air Force . . . "the Air Force takes good care of its own, *all* of its own." Its nurses play no small part in maintaining the validity of this legend.

Nursing Education and Nursing Service

ANA Committee on Infections

The Responsibility of the Professional Nurse in the Prevention and Control of Infections

The American Nurses' Association, the national professional organization and spokesman for registered nurses, recognizes the serious challenge confronting nursing and other health disciplines in preventing and controlling staphylococcal and similar infections transmitted by microorganisms.

The emergence of highly virulent organisms resistant to control by antibiotics has contributed to the danger and incidence of infections. Thus, effective programs for prevention and control are imperative.

By reason of their key position in patient care and in the supervision of auxiliary health personnel, professional nurses have a strategic role in such programs. The success of these programs requires the active participation of nurses in all areas of practice.

Effective action in regard to prevention and control of infection is no simple task. It necessitates continual review and enlargement of basic knowledge in light of new knowledge and developments.

There are several specific activities by which each individual nurse and the nursing profession can help assure success of programs designed to prevent and control infections:

1. Examine carefully present nursing practice in terms of the environment of each patient and according to established principles of microbiology, in order to prevent infection.
2. Identify nursing problems and practices which may need evaluation and revision with regard to existing knowledge about infections, and then help to develop conduct and report studies pertaining to these problems and practices. Recognize that small studies are significant in adding to the basic knowledge needed by the profession.
3. Practice strict asepsis in the care of patients, and help develop an "Aseptic conscience" among all staff members.
4. Develop nursing procedures based on sound principles of removing, destroying or preventing the transfer of microorganisms.
5. Participate in activities of control programs such as infection-control committees, and help develop effective systems for observing, recording and reporting vital information.
6. Work with other health disciplines and agencies to understand the problems of infections and methods of control.
7. Take part in local, state and national educational programs on the prevention and control of infections.
8. Read the professional journals and other sources for reports of studies on the prevention and control of infections, and bring this information to the attention of others.
9. Help develop interservice and interagency reporting and referral systems for infection problems in order to promote continued health supervision and care, both for the individual patient and the community.
10. Utilize every opportunity to educate patients, their families and the community on the prevention and control of infections.
11. Review basic nursing curriculums, both as to content of the principles of biological science and as to emphasis on the application of these principles.
12. Promote interservice education programs for all personnel in order to present current information on disinfectants, sterilization procedures, and methods of transfer of organisms.
13. Define the responsibility of nurses for educating and supervising other personnel who may influence the prevention and control of infection.
14. Make certain that allied disciplines on the health team understand the legal implications and responsibilities of the nurse in relation to problems of infection, and make sure that pertinent written policies, manuals, and guides are accessible to all personnel concerned.
15. Work with the administration of the employing institution or agency in providing proper physical facilities which are conducive to rendering safe patient care.
16. Assist in attaining proper working conditions, including an active employee health program that will encourage the reporting and treatment of minor illnesses and lesions, as a protection to both patients and employees.
17. Promote legislation which provides protection for the employee, including compensation for illnesses incurred on the job.

Group Work Principles in Psychiatric Nursing

The problem of therapy for emotionally isolated psychiatric patients has always been perplexing but challenging. Although it has been generally recognized that special attention is necessary for these patients, the scope and nature of such attention has never been fully explored. During the past two years it has been felt that a solution to part of this problem may rest in the direction of the use of social group work principles in psychiatric nursing.

With a grant from the National Institute of Mental Health, an excellent opportunity was opened to the Territorial Hospital in Kaneohe, to engage in an intensive experimental study in the use of this method.

Purpose of the Study Project

The purpose of the study project is to determine the feasibility of the use of social group work method by psychiatric nursing personnel, and the scope and extent of its use in the care of psychiatric patients.

Background of Problem

As in most psychiatric hospitals, large numbers of our patients must be treated by a minimum number of personnel. This is particularly true of our long-term patients whose treatment is the most difficult. In some of our wards, one or two members of the nursing staff may be responsible for the care of 60 to 80 patients. Faced with impossible therapeutic tasks, many of our personnel are forced into "custodial" attitudes. Under such conditions, individual attention or helpful emotional relationships are almost unavailable to the patients. It is equally impossible for ward personnel to experience the satisfaction of helping in any significant way or of playing a role as part of the professional treatment team. A frequent response to this somewhat overwhelming situation is what we have come to call "linen counting." This is the tendency of personnel to retreat into the safety of impersonal "busywork." The nursing personnel spend the day in such activities as counting the linen, mopping the floor, dusting the beds, taking patients to the toilet, checking patients' physical condition, keeping records, and "watching the patients." The ward physician, too, engages himself in such routine work as reviewing the order sheet, changing and ordering medications, checking various physical complaints of the patients, making quick "rounds," ordering sedation, and giving shock treatments.

In the above brief sketch, it is apparent that there is very little evidence of what might be called psychiatric treatment. This situation is especially true in certain of the closed wards, where the very regressed, chronic patients are hospitalized. There is the tendency to relate to patients in a distant manner to avoid the anxiety of rejection and frustration. Both the nursing personnel and the doctor tend to handle the patients by maneuvers which are unconsciously designed to keep the patients dependent. The attitude "nothing that we do will make any difference," seems to be common. Thus, it is easy to see that a circular process of mutual isolation is set up and perpetuated.

The Approach

Several approaches to the general problem described above were planned by the Territorial Hospital, one of which is the study described in this paper. This study is based upon the following concepts: (1) a ward of 60 patients is impossible for a nurse or psychiatric aide to treat; (2) if this "crowd" could be handled in smaller and more manageable groups, it would not only prove more rewarding to the personnel but more therapeutic to the patients. For example, a ward of 60 patients could be handled as six groups of ten with a nurse leading each of these groups in some sort of constructive goal-centered or relationship-centered activity daily. The frequency and type of the group experience would vary widely from ward to ward, depending on a number of factors. Small interacting groups, even at less frequent intervals, have much greater therapeutic potentials than mass random activity every day. It was from this kind of reasoning that the present study evolved.

For a number of reasons we turned to the field of social group work for help. First, the objective of the social group work method is to help individuals develop to their fullest capacity through participation in groups. The method provides experiences designed to assist individuals to develop an ability to participate as a group member, to increase their capacity to take part in decision making, and to accept the sharing of responsibilities. Individuals are further helped to develop a feeling of belonging and of security. These aims are quite in keeping with psychiatric treatment aims and seem particularly suited for dealing with the psychological isolation of the psychotic patient.

Another reason for seeking help from this professional field is their success in using volunteers and nonprofessional people as group leaders. A third reason is the traditional use of pleasurable activities involving the strength of the members rather than focusing on their weaknesses.

The Hypotheses

The original hypotheses for the project were outlined in May, 1957, as follows:

A. There are specific advantages in caring for patients in small groups because:
   (1) Patients are able to identify with a specific group.
   (2) Development of interpersonal relationships is facilitated.
   (3) Patients are helped to make desirable responses through purposeful group activity.
   (4) Small groups can be handled more effectively and guided more easily than large groups.
   (5) Observing and guiding individual patients in their activity is possible in a small group where it is impossible in a large one.

B. Nursing personnel can learn to be group leaders and the social group work method can be used as an additional tool by psychiatric nursing personnel:
   (1) The level of technical complexity can be controlled.
   (2) A working knowledge of the method and principle can be learned and understood.

C. The "activity group therapy" method is adaptable to the varied needs of our patients.
   (1) The relationship and the therapeutic approach can be at a level which is appropriate to the skills of the group leader and to the emotional maturity of the group.

Organization of the Study Project

Directed by the medical director and admin-

istered by the director of nursing, this type of "activity group therapy" is carried on and supervised by the nursing personnel. A social group worker provides consultation and in-service training in the group work method. In this setting the group worker does not function as a therapist nor does he work directly as a group leader. A nursing clinical instructor whose training, education, and personal qualities were particularly suited to the use of program skills was assigned to this project.

The Study Project

In December, 1957, a social group worker was employed.

The study project was organized for two closed wards, one for men and one for women. The patients on the men's closed ward were divided into five groups of twelve to fifteen patients, according to their level of illness and ability to participate. Each group was led by the nurse or psychiatric aide assigned to that ward. The personnel began by taking the patient groups out for walks around the hospital grounds or into the yard area. Every effort was made to see that each group held its session on the scheduled days. This was done by the staffs taking over for each other on days off or in cases of illness.

On the women's closed ward the "open ended" group was organized. This method was used because the disturbed patients' attention span is short and their anxiety is high. The basic difference in this type of group is that participants may join or leave during the session without disturbing the activity. It was discovered that special leadership skills were necessary for success in handling the "open end" type of group. Such leadership skills include the ability to appraise quickly the situation and adapt the activities on the spot, the ability to observe and sense movement toward participation by patients, and the ability to encourage joining or dropping while activities are carried out.

Emphasis was also placed on the use of spontaneous group activities. Some of these activities involved most of the patients on the ward in singing or game sessions for tension release, relaxation, and fun.

At the same time systematic training of nursing supervisors, head nurses, and charge aides to activity group skills was begun. The project was discussed with other members of the hospital staff.

The use of program skills such as games, dancing, and singing was a new experience to most of the nursing personnel. They were unsure of its use and how it related to their jobs. A course including games, party planning, folk dancing, and music was given for a two-fold purpose: (1) that these skills are fun and at the same time demonstrate their usefulness as tools; and, (2) that these skills can be readily learned and used. The first "skills" course (ten hours of theory and practice) was limited to supervisors, head nurses, and charge aides because it was important that key personnel be given guidance and assistance first in order to implement the program.

The second "skills" course was given to assistant charge aides. They were eager and willing to participate in this learning process since the course oriented them to some of the activities that could be used in mobilizing groups of patients.

The general aim of this project is to integrate group techniques in the *every day work* of the nursing personnel. It is essential that the staff develop enough group sensitivity to initiate activities spontaneously when needed.

At first the patients' reactions to coming together ranged from outward resistance, suspicion, hostility, and curiosity to passive obedience. The ability of the patients to come together was very limited. Early sessions lasted five to ten minutes with patients leaving and returning, but later the sessions lengthened to an hour or more when patients became accustomed to group participation.

The variations in response to group activities ranged from regressed patients building up a dependent relationship with the leader to a group of convalescent patients who have developed a well-structured group with their own program government and a high degree of interaction between the members with minimal assistance from the group leader.

With the regressed group, the nonverbal activity was extremely important. This was the means of communication between the patients and the leader. In the early meetings the group leader simply allowed a passive-dependent relationship to form. This was a beginning since there was little relationship at all before. Later, when the patients showed signs of group tolerance, they became aware of each other's presence and then began simple forms of interaction.

The activities carried on are simple and are kept appropriate to the interests and abilities of the particular patient group. They are of almost endless variety since the activity is not the end but a means to an end. In other words, the leaders are trying to help individual patients by using the group and group activity as a tool. Activities include household chores, simple games, sports, social games, gardening, sewing, cooking, bingo, singing, group discussions, group reading, and walks. The patients are encouraged to take an active part in the planning and selection of the activity. Criteria for selection of these activities include relationship factors, fun and relaxation, cooperative endeavor, and duties of group life.

Group composition is kept as stable as possible. The group meets about an hour, twice a week, at scheduled times and places. Occasionally, longer activities, such as parties or picnics, are planned and carried out. A significant factor in this process is the creation of a climate of acceptance and relaxation which will allow the members maximum opportunity for emotional growth in accordance with their needs and capabilities. Another factor considered is the adaptation of the programs to fit the changing problems of the group.

Observations and Results

In every group there have been significant and positive changes in the majority of patients. They show increasing interest in their activities by expressing to greater extents their opinions of the group's activities. For example, patients discuss and plan the types of games, dances, songs, and reading sessions they would like to have. Patients ask for special activities such as making wall decorations, party favors, sewing, gardening, and attending community functions. Patients take pride in the appearance of their wards and take better care of their supplies and equipment. Patients are less dependent and more expressive now that individual attention is given each of them. Nursing personnel know their patients better because they are planning and doing activities together. More patients understand what the staff is saying or doing. Patients are using their energy along more constructive lines. Patients help each other and relate to the personnel their feelings about care given them. Some patients are exceptions. These either have not responded or have occasionally been made too anxious by participation in the group to be able to continue. In such cases individual attention is given until they are able to participate.

The effect on the personnel has been very interesting. For example, before they were hesitant and reluctant to take part in activities with the patients. They felt their job was that of an overseer or "supervisor." They were uncomfortable in the new role of participating with patients. After demonstrations, classes, and actual practice sessions with patients, the staff found their work more challenging and interesting. They have rapidly increased their skills, both in the leadership of the activity and in their perceptiveness of the individuals in the group.

General Effects

Early in the project, it became apparent that the majority of our personnel who were not involved had various misconceptions about the purposes and values of the group activities. Group meetings were regarded as purely play to occupy the patients' time. It was also felt that valuable time was wasted on "hopelessly" ill patients. However, others recognized the therapeutic value of group activities and have sought assistance in learning about the project. Some aides have requested the opportunity to enroll in the classes; others are beginning to be aware that there *is* "hope for the hopeless." A more pleasant and therapeutic ward atmosphere is evident as staff is beginning to form spontaneous activity groups to meet patients' needs and interests. The nursing personnel are less reluctant to accept this new concept in psychiatric nursing.

Rosie K. Chang, R.N.
Director of Nursing Services
Hawaii State Hospital

District and Section News

Oahu

This past few months we have been very fortunate to have had "VIP" speakers at our general membership meetings.

In February, Mrs. Mary Lou Stielau, Models Hawaii, gave us a demonstration of "Is Your Face on Right?" This was an informal meeting with 90 or more members present.

An increased attendance was noticed at our March meeting when Dr. Clara A. Hardin was our guest speaker. She is Associate Executive Secretary of ANA, Research and Statistics. She was returning from the International Council of Nurses Seminar she had conducted in New Delhi, India, and had much to offer us from her experiences. Dr. Hardin has been Executive Director of the American Nurses' Foundation since 1955.

Continuing with our "VIP" contacts, Mrs. Irene B. Miller, Field Service Consultant, Committee on Careers, National League for Nursing, was our guest speaker of our April meeting jointly sponsored by Hawaii League for Nursing. Her topic was "Can We Meet Our Nursing Needs?" Prior to joining the staff of the Committee on Careers, Mrs. Miller was director of the New York City branch of the American Association for United Nations.

* * *

Mahalo for Super Savings Stamps.



At Pahoa Red Cross shelter nurses Emily Kaaua, center, and Taeka Kunimitsu get up-to-the-minute reports on lava flow from National Guard radio operator M/Sgt. Lionel Arruda at Pahoa disaster headquarters.

A Salute to the Hawaii County Nurses

American Red Cross, Hawaii Chapter, would like to salute the nurses of the Island of Hawaii for their wonderful service to the Kapoho evacuees and disaster workers during the recent volcanic eruption there. It was the second time in five years that they have been asked to volunteer their services at the Red Cross Disaster Shelter at the Pahoa School and they came through with flying colors.

In all Red Cross operated shelters, adequate medical and nursing services must be provided in order to protect the health of the evacuees. This means that 24-hour nursing coverage must be maintained for the entire time the shelter is in existence. Registered nurses are recruited through the local chapter nurse vice chairman of the disaster committee. On Hawaii, Miss Emily Kaaua has that position. She immediately began recruiting nurses. We requested one nurse for a 12-hour shift each night and there were usually two who came.

During the emergency period which was from January 13 through February 22, 1960, 25 registered nurses volunteered a total of 563 hours of duty at the shelter in Pahoa and at the First Aid Station which was in the disaster area.

All of these nurses who were not already enrolled as Red Cross Nurses have earned their badges and are being processed now.

Hawaii is privileged to have such nurses who willingly gave so much of their time to their community need and so spontaneously too.

Mahalo and aloha to all of you.

LOUISE CRUTE
Director, Nursing Services
American Red Cross, Hawaii Chapter

EACT Meeting

EACT section members had a stimulating panel discussion on "Teacher Tell Me How" with Olga Frojen, Senior Nursing Instructor, University of Hawaii, serving as moderator. Other panel participants were: Edith Wieneke, Pediatric Instructor at St. Francis; Judy Ortelt, Practical Nursing Instructor at Queen's; Flora Ozaki, Instructor of Maternal and Child Care at University of Hawaii; and Yukie Gross, Assistant Professor of Nursing at University of Hawaii.

Discussion focussed primarily on three areas: (1) How we can encourage student participation in class discussion. (2) How we can build up student confidence. (3) How we can best utilize student projects.

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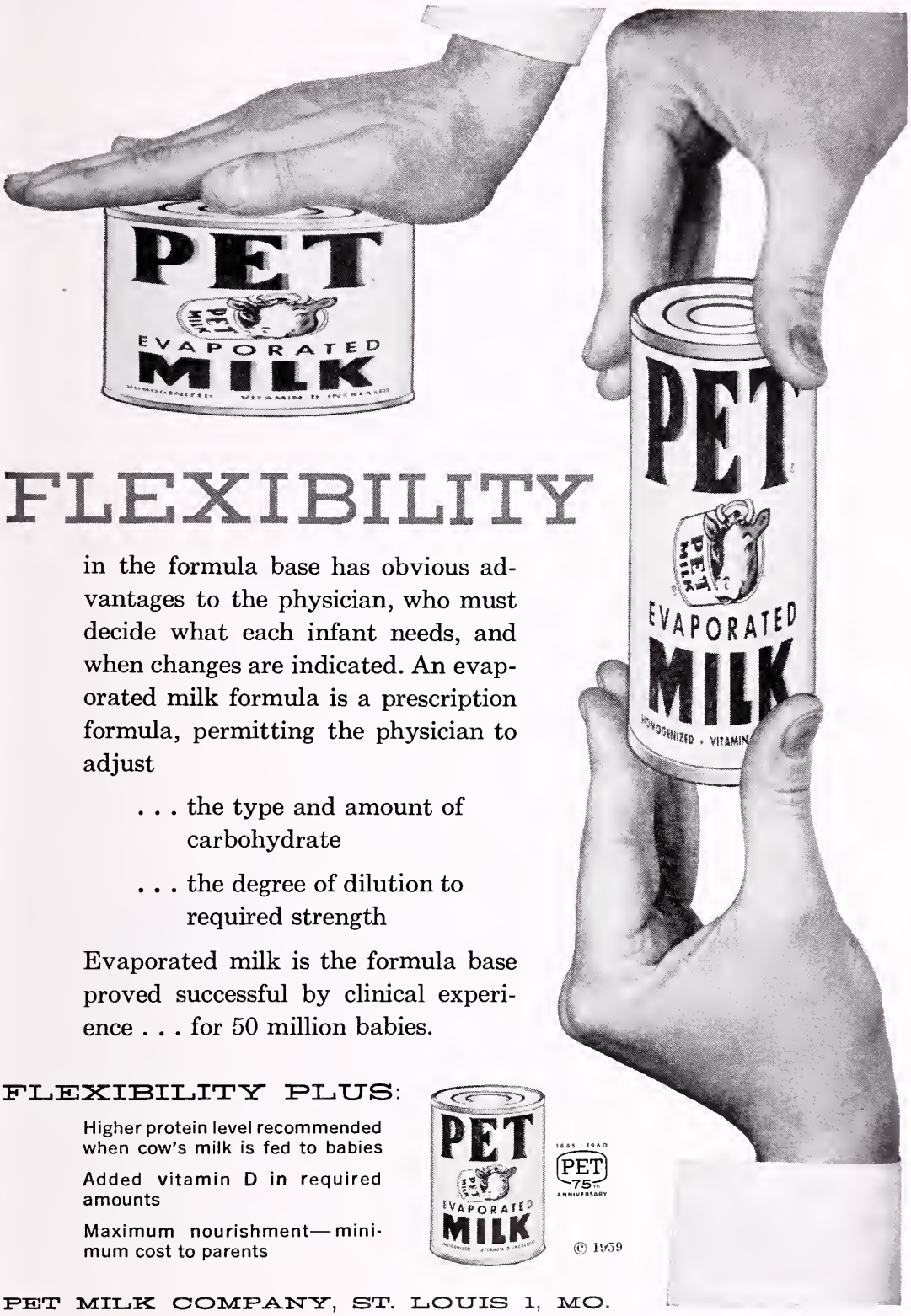
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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

ETHEL NISHIBATA, *Editor* MUN FOOK SHINN, *Associate Editor*

March Meeting

On March 8, 1960, Dr. John Ohtani spoke on exfoliative cytology of the female genital system. He stressed the importance of routine cytological examination and the pitfalls encountered in false negative and false positive results.

The value of cytology is found not only in cancer study but in other fields such as hormone study, somatic sex characteristics, trichomonad infection, and radiation response of the individual.

Cytology is used in research in radiation, DNA and RNA, tumor vaccines and antibiotics which may influence cancer.

Cytology Seminar

Development of the cytologic technic is largely credited to Dr. George N. Papanicolaou, who while studying the ovulatory cycle of the guinea pig in the 1920's noted the appearance of abnormal cells interspersed among the cells usually seen in uterine smears. Other scientists observed cells from malignant growths as early as the mid-1800's. Not until Dr. Herbert F. Traut, gynecologist, joined Dr. Papanicolaou in this research study was cytology given a real impetus.

Because of the accessibility of the cervix to smears and biopsy, the technic of exfoliative cytology has been most successfully applied in detecting cervical cancers while they are still in the curable stage. Adenocarcinomas of the endocervical canal, endometrium, and even the ovaries may be diagnosed with the aid of cytologic smears but with less accuracy. Smears from other parts of the body, such as the digestive, respiratory, and urogenital tracts or secretions and fluids from body cavities, may be studied but not as part of a mass screening procedure. Study of these systems presents two limitations: (1) followup biopsy is not always possible or wise, and (2) preparation and evaluation of these specimens require too much time. Cytology of other than the female genital system should be used as a diagnostic aid together with clinical findings. If a tumor does not shed malignant cells which reach accessible body cavities or openings, cytologic studies will be negative.

The uterus, about the size of a fist, is a pear-shaped organ with a body and neck. The endometrial cavity and endocervical canal are lined by simple ciliated columnar cells and the ectocervix and vagina by stratified squamous epithelium. The most common site of cervical cancers is the meeting of the two types of epithelium, the squamo-columnar junction. Therefore, some people believe that direct scrapings from this area afford the best results. Others feel that the vaginal secretion consisting of cells desquamated from the vagina, endocervix, and endometrium should be examined.

Smears are prepared by spreading a thin layer of cells on slides and immediately fixing in equal parts of ethyl alcohol and diethyl ether. Fixation in alcohol-ether fixative or some substitute (acetone or isopropyl alcohol) is complete in thirty minutes to an hour. Drying after, but not before, fixation is permissible.

Stains used are Harris or Mayer's hematoxylin, alcoholic orange-G, and eosin-azure—a mixture of light green, eosin, and Bismarck brown. The nuclei stain blue with the hematoxylin; the cytoplasm of cells of the deeper layers is basophilic-green or greenish blue; the superficial cells are acidophilic-pink; and the keratinized cells stain orange. Keratinization is abnormal for a mucous lining and is seen in both benign and malignant conditions.

The smears are examined under low power and are studied more closely under high dry when abnormal cells are seen. The system of reporting is as follows:

Class I—Absence of atypical or abnormal cells.

Class II—Atypical cytology but no evidence of malignancy.

Class III—Cytology suggestive of, but not conclusive for, malignancy.

Class IV—Cytology strongly suggestive of malignancy.

Class V—Cytology conclusive for malignancy.

Inasmuch as the cells which are searched for in

cytology arise from malignant neoplasms, it would be well to review the histologic criteria of malignancy. Applying this to carcinoma of the cervix, the noninvasive form is characterized by the following features in approximate order of descending importance: (1) abnormal cells, (2) maturation irregularity, (3) loss of polarity, (4) packing, (5) mitoses, and (6) absolute increase in depth of mucosa. Of these the only feature applicable to cytology is cellular abnormality. The morphologic criteria of malignancy are increased nuclear-cytoplasmic ratio, hyper-chromatism, clumping of chromatin, dense nuclear membrane, prominent or multiple nucleoli, and less significant cytoplasmic changes.

Many series have shown that cytology is an effective way of discovering significant cervical disease in the absence of clinical signs and symptoms.

Alpha Mu Tau Fraternity Grant

"Have Grants! Please Apply!" is the plea sent out by the Alpha Mu Tau, national honorary fraternity of medical technologists. They are offering two $250.00 grants to MT's (ASCP) for additional study in parasitology or mycology at the Communicable Disease Center, Chamblee, Georgia. Few technologists realize it, but the grants have been used less and less until this year they have had no applicants. These courses in mycology and parasitology are excellent and the C.D.C. makes no charge; the grant is used for expenses.

Application should be made and approved through the State Public Health organization. Successful applicants may apply for the grants to Miss Mary Nix, MT (ASCP), Chairman of the Scholarship Committee of Alpha Mu Tau, 11234 Glisan Avenue, N.E., Portland 20, Oregon.

The salute to Dr. Levine was promoted from this section to the editorial section in the middle of the magazine. See page 539. Thank you, Med. Techs!

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PROTECTION FROM NATIONAL COMPULSORY INSURANCE

(Continued from page 545)

passed and it seems that it will be only a matter of months before all state and county civil servants will be placed in a similar category.

The opportunity to budget for health needs has been afforded by many voluntary plans and commercial insurance companies. Many of the plans, because of their very nature (indemnity only, and in-hospital care only) have made it impossible for the public to budget for sickness and catastrophic illnesses. The failure to provide outpatient medical benefits in mainland U. S. plans has probably been the main motivating force behind the pressure for compulsory national health insurance.

In Hawaii we are fortunate in having a plan such as HMSA which has offered home and office visits as a part of its benefits to the subscriber and dependents on an equal basis for many years. This is unique in prepayment plans, and it deserves the full support of all physicians who would oppose national control. By such support and united efforts we could be responsible and assist the plan to increase benefits and establish more equitable fees for the physicians without increasing the cost to the public.

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COUNTY SOCIETY REPORTS

(Continued from page 551)

speakers Ben Dillingham, Vice President and General Manager of OR&L, and Robert Dodge, Attorney with Heen, Kai & Dodge. A question and answer period followed.

President H. Q. Pang called the meeting to order at 7:40 P.M. Approximately 135 members were present.

Dr. Pang welcomed into the Society two new active members Dr. George Ferdinand Schnack and Dr. Frank S. Akamine. New associate member Capt. Larry James Otterness was not present.

Public Law 86-382

Dr. Pang announced that by Board of Governors action at its last meeting, information on our local status regarding the Federal Employees Health Benefits Act of 1959 had been circulated to the general membership and that the meeting was now open to discussion on this. He mentioned that we have not as yet heard from Washington regarding Hawaii's request to qualify under Plan 4(4)(B) with an income ceiling.

A lengthy discussion followed with the membership expressing their opinions freely.

In answer to a question as to whether HMSA will make available a choice of another plan if the doctors do not want Plan 4(4) (B), it was brought out that the law states that an organization can only qualify under one plan and that you can't have both. (It was later demined that HMSA may qualify under both #1 and #4(4) (B), and that #1 must be offered in Hawaii.)

It was mentioned that HMSA automatically qualifies under Plan I, with income ceiling of $6,000 but without home and office visit, but because this puts HMSA in a poorly competitive position with a plan which offers home and office visit, HMSA has asked to spin off from Plan I and has applied for approval under Plan 4(4)(B) with home and office visits and a special request to retain the income ceiling.

Considerable discussion was held on whether the Society should fight to keep the income ceiling.

Reference was made to a letter from King County Medical Service Corporation stating that a poll of their entire doctor membership showed that better than 80% of 1,050 doctors polled returned ballots favoring the removal of the salary limits.

Dr. Nishigaya, speaking as President of the HMA, stated that he would like to see every member in good standing have a fair "shake" in this program and that he would like to see a ballot sent out to the entire membership to see how they felt about keeping the income ceiling and that the course of action for the Society be taken according to the majority rule. He further stated that he had visited the outside islands personally to see how they felt about this income ceiling and that their decisions were as follows:

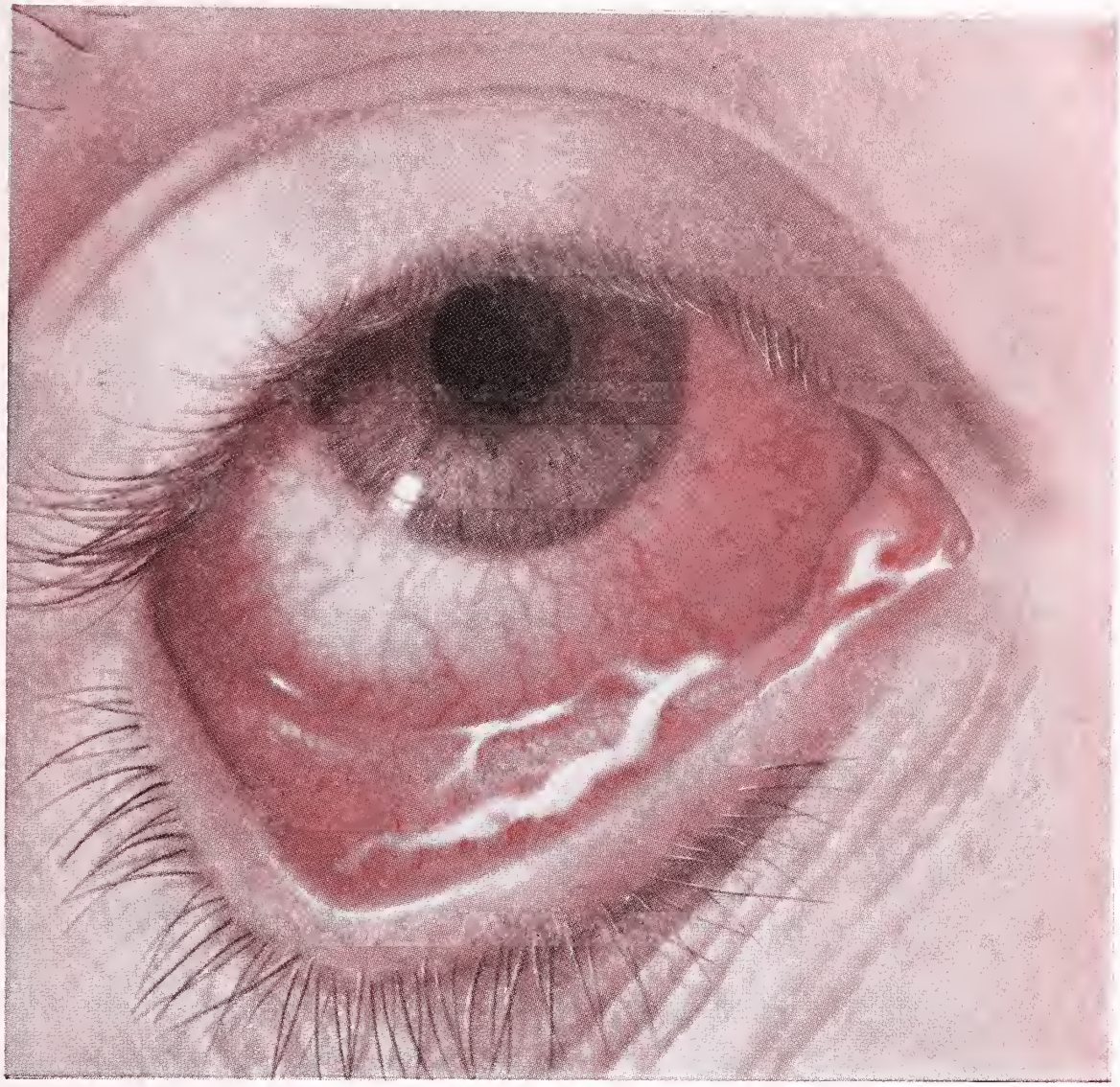
Kauai voted to go along with 4(4)(B) without income ceiling.

Maui decided to go ahead without the income clause but would take whatever the Honolulu County decided to take.

Hawaii will take plan 4(4)(B) with or without the income clause but let Honolulu County try to get the income clause.

Dr. Sakimoto who spoke in favor of having the income clause removed made the following motion:

(Continued on page 572)



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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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COUNTY SOCIETY REPORTS

(Continued from page 570)

"In the event the Federal Civil Service Commission turns down our request to qualify with an income clause, that a poll be taken of our membership, by mail, to determine whether or not the membership will agree to remove the income clause on a medical plan for the Federal Civil Service Employees. The poll should consist of the following question and the results shall be binding upon the officers of this Society in negotiating future contracts.

I agree to have the Income Clause removed for a Medical Plan, which qualifies under Public Law 86-382- Section 4(4)(8) for the Federal Civil Service Employees.

☐ Yes ☐ No

The motion was seconded by Dr. Cloward.

Further pro and con discussion ensued. It was brought out that if we removed the income ceiling for Federal employees we would ultimately have to do it for other groups as they will want the same thing.

Dr. Moore, who was asked to speak as past chairman of the Medical Care Plans Committee, stated that it would be perfectly all right to remove the income ceiling provided we had an adequate fee schedule which, however, we do not, and that he would like to reiterate and remind the doctors again how difficult it was to even get the HMSA fee schedule up half way to our Relative Value Schedule.

Dr. McCorriston cautioned the doctors not to panic but to go slowly and not to rush into things. He also suggested writing to our own congressmen asking them for assistance in getting our request approved.

In addition to the circularized information, Dr. Nishigaya briefly brought the membership up to date on our correspondence with the Civil Service Commission. He mentioned that we have not heard from Washington as yet, but that a wire from Mr. Ruddock to Albert Yuen of HMSA informed him that the Commission has not yet made a decision on the problem presented in our letter to Mr. Ruddock (a copy of letter was circulated) and that the commission will advise us very soon.

It was brought out by Dr. Woodruff that perhaps we should wait to hear from Washington in answer to our request first before we went ahead and voted on Dr. Sakimoto's motion to poll the membership.

It was also felt that a poll such as the one suggested, held prematurely, might place the Society in jeopardy, and that it might be a good idea to wait until we heard from Washington before we decided what step to take next.

A motion was made by Dr. Vasconcellos to table the motion made by Dr. Sakimoto. The motion to table was duly seconded and carried.

The meeting was adjourned at 10:20 P.M. Refreshments were served in the lanai.

* * *

The Honolulu County Medical Society held a special membership meeting on Tuesday, February 23, 1960 in the Hawaiian Electric Auditorium. President H. Q. Pang called the meeting to order at 7:45 P.M. Approximately 200 members were present. Drs. Wipperman, Burden and Wade from the neighboring islands were welcomed.

Public Law 86-382

President Pang informed the membership that the Society was indeed fortunate to have Drs. Morton E. Berk and O. D. Pinkerton represent its members for five days in Washington D.C. negotiating with the Civil Service Commission on this Federal Medical Insurance for government employees. He stated that Joe Veltmann and Albert Yuen of HMSA also went to Washington and assisted our two MD's in the negotiations.

Before the meeting was turned over to our two representatives, it was announced that the Chair would not entertain any motions until Dr. Berk and Dr. Pinkerton had presented their information, and after a question and answer period.

Dr. O. D. Pinkerton, who was called upon to give the background information on Public Law 86-382, explained the purpose of the bill, how it was introduced, and what it hopes to accomplish. He made reference to the Congressional Committee reports and also about the conferences they had with our three Congressmen from Hawaii.

Dr. Berk presented a detailed account of his meeting in Washington and went into the results of the conferences and negotiations with the Civil Service Commissioners and other officials. He stated that at the close of their meeting, they were informed by Mr. Ruddock that they could not have the ceiling clause, that although the Commissioners were very sympathetic to our appeal, they reaffirmed their previous decision which would not allow us to operate on Plan 4(4)(B) with an income ceiling. Dr. Berk was assisted in his presentation by Mr. Veltmann. Dr. Berk informed the membership that an extension of time for qualifying for a plan has been granted to March 7. He then presented, on the blackboard, proposed figures for the medical coverage under Plan 4(4)(B) based on what the Commission would agree on. He later mentioned that these figures would have to be gone over by the actuaries and must be acceptable to the HMSA Board of Directors.

(Continued on page 574)

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COUNTY SOCIETY REPORTS

(Continued from page 572)

Proposed Plan 4(4)(B)	HMSA Pays	MD Charges	Subscriber Pays
*First visit for any illness is deductible**			
Non-surgical accidents (1st visit)	$ 3.00	$ 5.00	$2.00
Office Visit (subsequent)	3.00	5.00	2.00
Home Visits (7 a.m. to 6 p.m.)	5.00	8.00	3.00
Home Visits (6 p.m. to 7 a.m.)	5.00	10.00	5.00
Extra Patient on home visit	2.50	4.00	1.50
1st Hospital Visit	3.00	5.00	2.00
Hospital Visit (subsequent)	3.00	4.00	1.00
Consultation (one per illness)	10.00	10.00	None
(Drugs are not included in the above costs. Patient pays for all drugs except what is incorporated in their hospital plan.)			
Preventive Medicine Care:			
Immunizations	2.00	3.00	1.00
Physical Examination (once in 2 yrs.)	3.00	6.00	3.00
Well baby examination (once a month for the first year)			

* See next meeting report. This was later changed.

It was mentioned that the Commission was most concerned over the last three items in Preventive Medicine Care.

It was also mentioned that obstetrical cases were on a strict indemnity basis—$100 for the hospital and $100 for the doctor.

A lengthy question and answer period followed. After a thorough discussion by the membership and a summarization by Dr. Robert Faus, Dr. Pang thanked Dr. Berk and Dr. Pinkerton and HMSA for doing such a fine job under a difficult situation.

A motion to poll the membership by mail on whether or not they wish to participate in Plan 4(4)(B) was made by Dr. Richard Sakimoto and seconded.

A motion to table Dr. Sakimoto's motion was made by Dr. Reppun, seconded and carried.

A motion to accept Plan 4(4)(B) was made by Dr. McCorriston (who was opposed to acceptance) and seconded, but did not pass, with 57 yes and 61 no. Since the vote was so close, a recount was requested.

A motion that the voting be by secret ballot was made by Dr. Ando and seconded, but did not pass.

A motion to adjourn the meeting was made by Dr. McCorriston and seconded.

A motion to table the motion to adjourn was made by Dr. Richert, seconded and carried.

A plea for a secret ballot in order to determine the accurate count on Dr. McCorriston's motion to accept Plan 4(4)(B) was made and approved.

Following a count of the ballots by tellers Nishigaya and Marnie, it was announced that the motion did not pass for lack of a majority vote. The result was 78 yes and 78 no.

A motion that any physician who desires to participate in Plan 4(4)(B) as individuals may sign up with HMSA with Honolulu County Medical Society approval was made by Dr. Sakimoto and seconded, but did not pass.

The meeting was adjourned at 11:07 P.M.

* * *

The Honolulu County Medical Society met on March 1, 1960. A talk entitled "Current Concepts of Rheumatic Fever" was presented by Dr. Albert Dorfman, Professor of Pediatrics and Director of La Rabida—University Chicago Institute.

Approximately 213 members were present. New associate member Dr. Norberto Baysa was welcomed into the Society by Dr. Pang. Dr. Rudolph Maffei, new active member, was not present.

Public Law 86-382

President Pang announced that February 21 a petition signed by 10 members was received requesting a special meeting to reconsider the Society's approval of individual members participating in Federal Plan 4(4) (B), and HMSA offering this plan. It was decided to put this subject on tonight's agenda.

Dr. Berk reviewed the proposed fee schedule for Plan 4(4)(B) for medical coverage and answered questions concerning the fees. A letter from Dr. Sumner Price, Administrator of Queen's Hospital, stated that "the voluntary hospitals of Honolulu are concerned over the possible loss of patients if HMSA is not designated as an agent to carry an insurance plan for Federal employees."

Dr. T. Nishigaya made a brief statement why he felt individual doctors should be allowed to participate in this plan and on behalf of these individuals he presented the following resolution:

> **Whereas,** The Federal Employees Health Benefits Act of 1959 (Public Law 86-382) is a law of our land that is exacting certain compromises on our basic principles of voluntary comprehensive medical service plan for which the Honolulu

(Continued on page 576)



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in infectious disease[17,22,30,36]
in arthritis[18,19,20,29]
in hepatic disease[2,3,4,5,38]
in malabsorption syndrome[1,2,6,27]
in degenerative disease[6,7,19,20,40]
in cardiac disease[23,28,29,38,41]
in dermatitis[24,39]
in peptic ulcer[8,21,38]
in neuroses & psychiatric disorders[25,26]
in diabetes mellitus[31,32,33,38]
in alcoholism[9,11,35,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[13,19,20]
in pancreatitis[15]
in female climacteric[12,34]

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1-41 a list of the above references will be supplied on request.

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COUNTY SOCIETY REPORTS

(Continued from page 574)

County Medical Society has serious objections; and

Whereas, A law in our society demands the fullest cooperation of all in the orderly process of perfecting the law and administration of the law; and

Whereas, The people of our State who are beneficiaries of this legislation continue to deserve the best medical care and hospital service when in need; and

Whereas, A realistic economic freedom and opportunity to select the doctors and hospital of their choice should continue to be available to all; be it

Resolved, That the Honolulu County Medical Society offers the cooperation of the Society and its doctors to Hawaii Medical Service Association (HMSA) in its participation as a carrier of a comprehensive individual-practice prepayment plan under Section 4, paragraph 4-B of this Act; and be it

Resolved, That the Medical Care Plans Committee of our Society be instructed to eliminate any provision limiting benefits under this act on the basis of income and to assist the Hawaii Medical Service Association (HMSA) in obtaining for the beneficiaries of the Act and the Doctors of the Society the most equitable benefit schedule under the law; and be it further

Resolved, That the officers, Board of Governors and the Medical Care Plans Committee recommend to the Society after careful analysis of the Act and its administration, any proposals for amending inequities and untenable compromises of principles in the Act or the Regulations pertaining to this Act.

A motion for the adoption of the resolution was made by Dr. Nishigaya and seconded by Dr. Edmund Lee.

Dr. Hartwell presented an amendment which included another "Whereas" following the first stating that the Honolulu County Medical Society in cooperation with the HMSA could offer a more comprehensive and economical plan for the beneficiaries but have been denied by the U.S. Civil Service Commission. It was pointed out that the Commission acted through its interpretation of the Act. It was decided that this be incorporated in the amendment.

Motion that an amendment with the above points and with the latter addition be incorporated in another "Whereas" by a committee, was made by Dr. Hartwell, seconded by Dr. Palma and was carried.

In the discussion which followed, Dr. Nishigaya said it was the intent of the resolution that contracts would be made by physicians directly with HMSA rather than through the Society.

A thorough discussion was had by the membership and it was the general feeling of the members that since the law has been passed, there is no point in saying it doesn't exist. Something should be done to preserve the patients the doctors now have and in order to remain competitive we should adopt this plan.

Dr. Nishigaya's resolution was then voted on and was accepted by an overwhelming standing majority vote of the membership.

B. M. E. Annual Report

Mr. Richard M. Kennedy presented the annual report of the Bureau of Medical Economics. A brief question and answer period followed. The report was placed on file at the Honolulu County Medical Society office.

A question was raised whether the profits from the Bureau can be used to defray the expenses of the Honolulu County Medical Society thereby reducing the membership dues. Mr. Kennedy stated that there is some question whether this is legal and that the Executive Committee of the Bureau will definitely come up with some recommendation concerning this in the near future.

There being no further business, the meeting was adjourned at 9:55 P.M.

* * *

The Honolulu County Medical Society held a special meeting Tuesday, March 8, 1960 in the Hawaiian Electric Auditorium. Approximately 105 members were present.

Public Law 86-382

Dr. Berk stated that the final plan was just about ready to go in, however, there have been some changes which concern:

(1) maximum amount payable by the member if charged and the amount to be paid by HMSA which involves a cut in the major medical expense portion of the program (from $10,000 to $7,500) and
(2) that the deductible for home and office visits has been ruled out.

(Continued on page 580)



Lila G. Ponce, R.N.
Director

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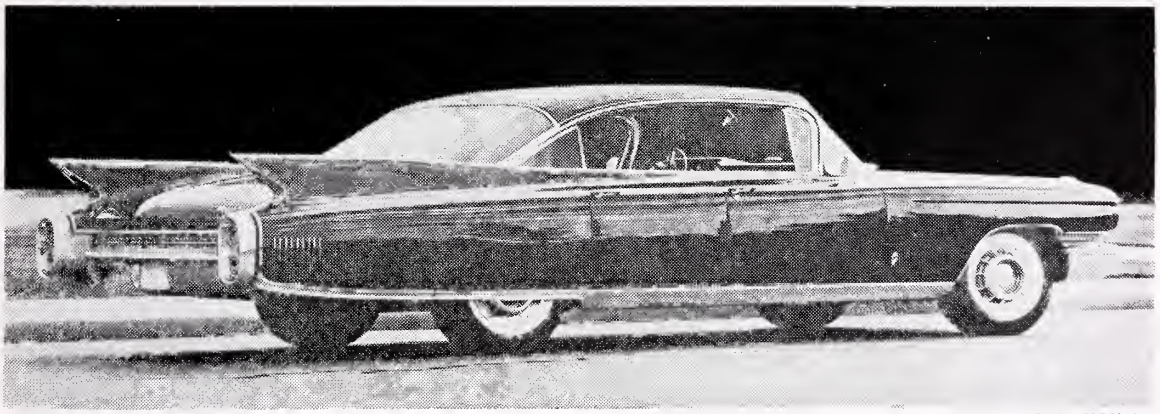


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O ORAL DOSE	*PENICILLINASE*	*IN VITRO*

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BRISTOL





(Continued from page 576)

When we informed the Commission that we understood in the original negotiations the first call was deductible, we were told by them that "let's just say there was a misunderstanding." We were also informed that both Washington State and Idaho have received similar notices.

Dr. Pang informed the membership that he spoke to Mr. Veltmann about participating physicians and he was told by Mr. Veltmann that HMSA reserves the right to accept whomever they want and to reject whomever they want. Participation is all on an individual basis.

A review and question and answer period led by Dr. Berk was then held by the membership on all aspects of Public Law 86-382.

Dr. Ando called attention to an article in "Medico News" which stated that "After the printing of the Civil Service Commission drafted regulations in the Federal Register, interested parties will be given 30 days to make comments on these regulations. The Civil Service Commission will then consider these comments." Dr. Berk stated that this was worth looking into. Dr. Arnold suggested that because of the time limit that a phone call be made instead of writing or cabling.

A question asked by Dr. Chinn if HMSA will honor assignments of non-participating physicians was answered by Dr. Faus who stated that HMSA will follow through the same as it is doing now with non-participating physicians; i.e. if the patient certifies in writing that he has received the services and assigns the benefits directly over to the doctor, payments will be made directly to the doctor.

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It was also brought out that if a patient wishes to go to a non-participating doctor of the plan, he may do so with the understanding that the plan will only pay the benefits that the plan specifies and if the doctor charges more than what the plan specifies, the patient will pay the difference.

Dr. Bachmann asked if this change in the contract is just the beginning of a series of changes by the government. Dr. Berk answered that in their conversation with Mr. Ruddock this question was asked and they were informed by him that as far as he could see there were no other major changes except for some minor changes, and these had to do with the wording, etc.

Dr. Morgan asked if we would still be competitive with the Kaiser Plan because of this change, and Dr. Berk asserted that no one knows what the premiums of other plans are and that he himself does not know what HMSA will offer, however, he has been assured that HMSA's plan is still competitive.

With regard to the length of the contract period, the membership was informed that the first contract period will run from July 1, 1960 to October 31, 1961 (16 month period). Subsequent periods will be a twelve months contract period.

O. D. PINKERTON, M.D.
Secretary

Kauai

The regular monthly meeting was held on November 3, 1959, at 7:45 P.M. in the library of the Wilcox Memorial Hospital.

Dr. Worth reported that the local Civil Defense Office had turned down the request for supplying mobile radios for doctors' cars, but that they were interested in trying to supply a base station at each hospital and at CD headquarters, to be used as a medical net in an emergency. Doctors could supply their own mobile sets to use these facilities for their own convenience at other times if they wish. The matter is being explored further.

Dr. Worth reported that the request to the Board of Supervisors to pay for medical care now furnished to County pensioners, with freedom of choice of physician, has been referred to the Finance Committee for study and a report.

Dr. Boyden pointed out that he has been our HMA delegate this year, but that he has not been asked for a report of his activities. It was suggested that he give a verbal report at our regular Society meetings as such activities occur.

* * *

The regular monthly meeting was held on December 8, 1959, at 7:35 P.M. in the Lihue Plantation Training Center.

Doctor Wallis raised the problem of tourists who suffer falls or other slight injuries, who do not themselves wish medical attention, but who go to the doctor for an examination at the urging of the hotel or tour manager. Sometimes no one in this situation is willing to accept financial responsibility, and the doctor is left holding the bag. It was suggested that we try to meet with hotel managers on this issue to come to some satisfactory solution.

* * *

The regular monthly meeting was held in the Wilcox Hospital library at 7:30 P.M. on Tuesday, January 5, 1960. Guests present were Dr. Nishigaya, Dr. Frazer,

(Continued on page 582)



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COUNTY SOCIETY REPORTS

(Continued from page 580)

Mr. Joe Veltmann, Dr. Rusch, Dr. Stevenson, and Mr. Watanuki.

Dr. Worth reported that the Chairman of the County Board of Supervisors' Finance Committee was sympathetic to our request for free-choice, fee-for-service paid medical care for County pensioners, and he had requested a letter from us with specific proposals. Drs. Worth, Boido, and Fujii were requested to draw up such a letter.

Dr. Worth announced his departure for the University of California at the end of this month, and he was voted unanimously into the status of an Honorary Member of the Kauai County Medical Society.

Dr. John Frazer, Dr. Nishigaya, Mr. Joe Veltmann, and our membership had an extensive discussion of the role of HMSA and the new insurance program for Federal employees. Finally it was moved by Dr. Cockett, seconded by Dr. Wade, and unanimously approved by the membership that HMSA be asked to try to qualify under Plan 4b, with the removal of the income clause for surgical fees. It was then moved by Dr. Wade, seconded by Dr. Cockett, and unanimously approved by the membership that if HMSA fails to qualify under 4b, then it should qualify under Plan 1 (Blue Cross; Blue Shield nation-wide service plan).

Elections were then held with the following results:

President .....Dr. Boido
Vice President .....Dr. Cockett
Secretary-Treasurer .....Dr. Brennecke
HMA Delegate .....Dr. Wade
Board of Censors.....Dr. Wallis (vice Dr. Boyden)

ROBERT WORTH, M.D.
Secretary

* * *

The regular monthly meeting was held in the Wilcox Hospital library at 7:30 p.m. on Friday, February 5, 1960.

A motion was passed that the president appoint a committee to explore further the possibilities of establishing a base station in the two hospitals on Kauai and of the doctors supplying their own mobile sets in order to use mobile radio facilities regularly and to be prepared in case of an emergency. Dr. Brennecke was appointed, but he requested the assistance of Dr. Goodhue.

A motion was made, seconded, and carried unanimously that the secretary-treasurer write a letter to Dr. Richard K. C. Lee, president of the Department of Health, stating that Dr. Worth services to the medical profession during his stay on the island of Kauai was outstanding.

The business meeting was followed by a talk on "Rheumatic Fever" by Dr. Dorfman, Professor of Pediatrics at the University of Chicago, who is now Visiting Professor at the Children's Hospital in Honolulu.

MARVIN A. BRENNECKE
Secretary

* * *

The regular monthly meeting was held in the Wilcox Hospital library at 7:30 P.M. on March 1, 1960.

Dr. Goodhue reported on the subject of the use of mobile radio facilities by the members of the society. He stated that General Electric and Motorola equipments were available on Kauai. The cost per auto would be approximately $900.00. Dr. Brennecke reported that the OCD believed that it could obtain the two-base stations needed on Kauai, one at Waimea Hospital and the other at the Wilcox Hospital. The OCD was not certain whether it had funds to purchase any of the mobile units for the automobiles. The OCD will report to us as soon as they have a definite answer.

The secretary informed the members that Dr. Boido, the president, had requested him to write a letter to Mr. Joe Veltmann confirming a telephone message to him on February 27, stating that all the members of the Kauai County Medical Society except one were in favor of removing the income clause from a contract with the federal employees. Dr. Boido stated that he made this survey on February 27, by seeing each doctor personally or phoning him.

The business meeting was followed by an Audio Digest entitled "Parenteral Fluid Administration Post-Operatively" by Philip Thorek.

* * *

A special meeting of the Kauai County Medical Society was held on Tuesday evening, March 8, 1960, after the Wilcox Memorial Hospital staff meeting was held.

A motion was made by Dr. Boyden and seconded by Cockett that the Kauai County Medical Society would prefer to sign the acceptance of participating in the Federal Employees Medical Plan on a Kauai County Society basis with HMSA, but with the information given at this meeting that it is compulsory for each member of the Society to sign this contract individually, it is agreed that each member sign the contract with HMSA as presented, except that Section 8 be changed to read as follows—"This agreement shall continue in force for the period July 1, 1960 through October 31, 1961," with deletion of the rest of this section.

During the meeting Dr. Boido stated that he phoned Mr. Dick Kennedy today, and asked for the Honolulu County Medical Society legal opinion as to the necessity of individual physician contracts with HMSA for the Federal Employees Plan. Mr. Kennedy replied that he had asked for a legal opinion today and that the lawyer stated that there is nothing in the law which requires contracts between the individual participating physician and the carrier.

Mr. Kennedy said that non-participating physicians may be visited by the Federal Employees, but that the doctor cannot collect from HMSA but must collect from the patient. Likewise, the non-participating doctor is not required to follow the HMSA fee schedule.

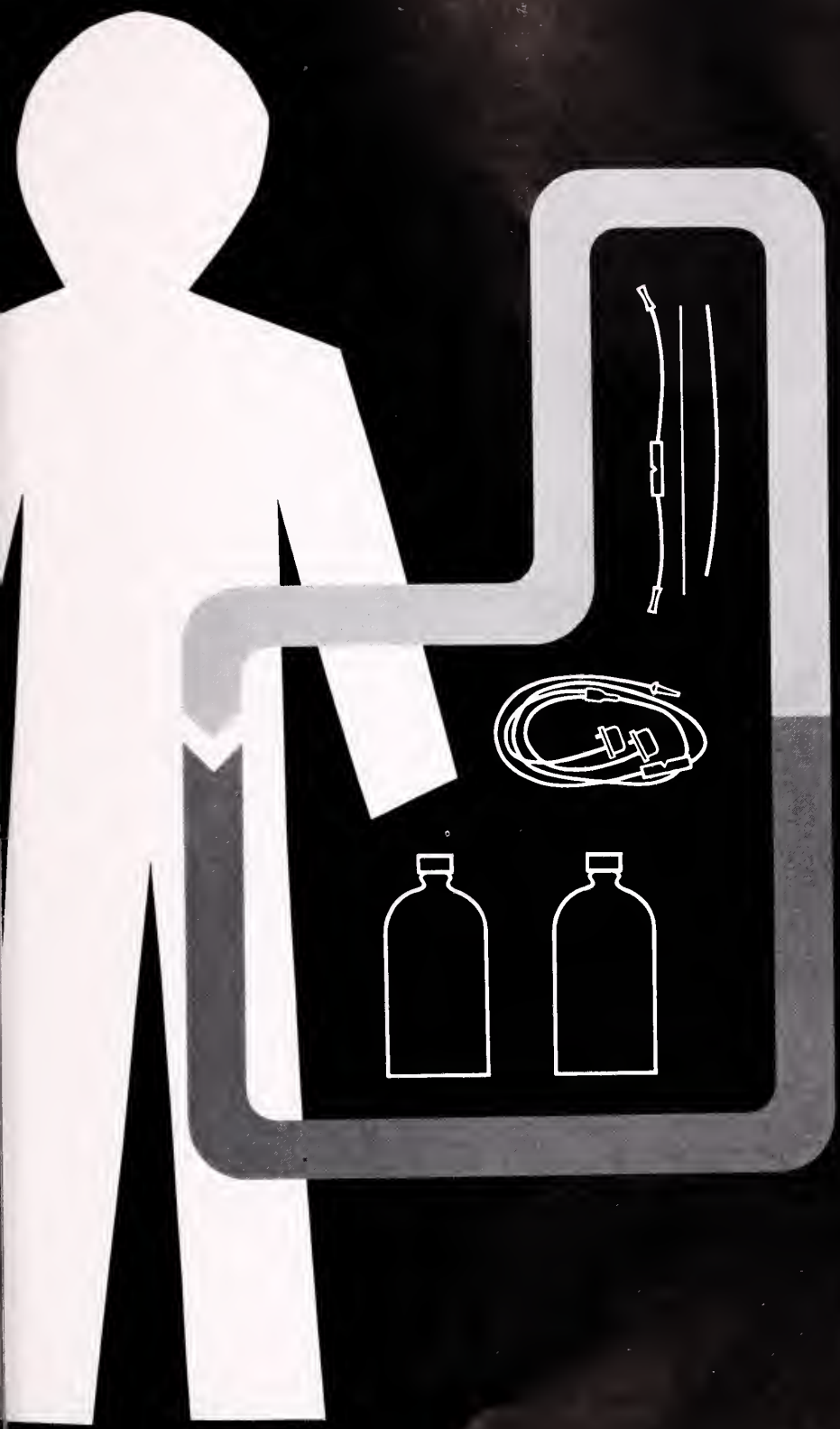
* * *

The regular monthly meeting was held in the Wilcox Hospital library at 7:30 P.M. on April 5, 1960. The members present were Drs. Boido, Cockett, Fujii, Goodhue, Ishii, Kim, Kuhns, Masunaga, Wade, Wallis, and Brennecke.

The secretary-treasurer gave the financial report showing a balance of $217.28 in the Bishop National Bank, March 31, 1960.

A motion was passed to rescind the motion binding the members of the Society (in reference to signing the individual contract with HMSA for Physicians Participating in the Federal Employees Medical Plan) to the deletion of part of Section 8 as follows: "unless sooner terminated by either party on thirty days' notice, which shall be in writing but need not specify any cause" from

(Continued on page 584)



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*References: Maxwell, M. H., et al: Peritoneal Dialysis:
1. Techniques and Applications,
J.A.M.A. 170:917 (June 20) 1959.

Doolan, P. D., et al: An Evaluation of
Intermittent Peritoneal Lavage,
Am. J. Med., 26:831 (June) 1959.

COUNTY SOCIETY REPORTS

(Continued from page 582)

the entire Section 8 which reads as follows: "This agreement shall continue in force for the period July 1, 1960 through October 31, 1961, *unless sooner terminated by either party on 30 days' notice, which shall be in writing but need not specify any cause.*"

Dr. Kim was appointed by the president as the alternate delegate to the Hawaii Medical Association for Kauai.

A film made available by E. R. Squibb & Sons through Mr. Henry Peterson, "Hypertensive Cardiovascular Disease—Challenge to Management" was shown for the scientific part of the meeting.

MARVIN A. BRENNECKE, M.D.
Secretary

Maui

A regular meeting of the Maui County Medical Society was held on March 4, 1960, at 8:00 P.M. at the Wailuku Hotel. Introduced were members of the Hawaii Medical Association Council, including Drs. Nishigaya, Allison, Spencer, Burden, Bergin, and Cushnie, and Miss McCaslin, Executive Secretary.

Dr. Nishigaya, President of the HMA, took the floor and announced the Council was meeting on Maui and that he thought the neighbor islands should know what the parent organization in Honolulu is doing, and these meetings would be scheduled in the future to rotate on the different islands. He then announced that the Honolulu County Medical Society had agreed to go along on an individual basis with HMSA in their proposing a contract for Federal Medical Service Insurance.

Then President Nishigaya at 8:40 P.M. called an official meeting of the HMA Council.

A letter from the Board of Examiners about a roster of doctors was read but no action was taken.

Discussion concerning taping of a TV program and the cost to the association then followed, and it was moved by Dr. Spencer that the HMA approve the expenditure of approximately $1,200 a year to put the TV programs on tape.

After some discussion, the proposed raise of the Executive Secretary was approved and the meeting then adjourned at 10:40 P.M.

S. OHATA, M.D.
Secretary, Pro tem.

BOOK REVIEWS

(Continued from page 549)

great need in the accumulating knowledge of today to read rapidly and well, the need of a new method that will save many students graduating from our schools the agony of failure due to reading and writing difficulties is evident.

Mrs. Spalding has worked out a method that will prevent most of the handicaps that have bothered so many children. The author, on the basis of Dr. Orton's original work, has developed a systematic, easily understood method that works. As a true scientist, after she had evolved what she thought was a good method, she then tried it in many different schools in comparison with other methods. She has also had classes for teaching teachers and parents and has tried it on individual students. This method is part of the regular curriculum of most of the 24 Catholic schools of the State. I have had the opportunity of sitting in on a first grade class and listening to them read and write readily third grade words after seven months of schooling. The teacher told me that in her 28 years' teaching experience she has not been able to accomplish so much in such a short time and for so many with any other method. The teacher and the 58 pupils (as well as the parents) were enthusiastic about what the method had accomplished.

This book will interest every doctor for he is usually the first one asked, "Why can't my bright Johnny learn to read, spell, and write?" This book gives the answer. It is well illustrated and carefully documented. It will help the doctor to indicate an avenue of help to the parents whose children have this handicap. I recommend that this book be studied carefully by every nurse, doctor, and parent.

NILS P. LARSEN, M.D.

Orr's Operations of General Surgery, 3rd Ed.

By George A. Higgins, M.D., F.A.C.S., and Thomas G. Orr, Jr., M.D., F.A.C.S., 1,016 pp., $20.00, W. B. Saunders Co., 1958.

The third edition of this book has shown some revision in that it has added thoracic and cardiovascular surgery technics. As was noted in the previous editions, only the well established and standard proven technics in general surgery are demonstrated. The illustrations, although seemingly adequate, are lacking in others. This book is still a good book in general surgery for general reference. Medical students, interns and residents, as well as practicing surgeons will find it useful for quick reference.

WALLACE W. S. LOUI, M.D.

Venereal Disease, Old Plague—New Challenge

By T. Lefoy Richman, 20 pp., $.25, Public Affairs Pamphlet No. 292, 1960.

This booklet by the Associate Executive Director of the American Social Health Association presents clearly and accurately the venereal disease problem as it exists today in the United States. While the booklet was written for laymen, young physicians might well read it to learn of the present VD problem and methods used to meet it. Older physicians will be interested in the changing approach to venereal disease control.

SAMUEL D. ALLISON, M.D.

Open Reduction of Common Fractures

By Oscar P. Hampton, Jr., M.D., F.A.C.S., and William T. Fitts, Jr., M.D., F.A.C.S., 212 pp., $8.75, Grune & Stratton, 1959.

This small, 212-page surgical monograph covers the field of choice between open and closed treatment of fractures, coming from two teachers plus investigators. The material offered is authoritative and clear. A different-colored type paraphrases the pitfalls and precautions seen in each of the fractures discussed. The authors caution against the careless approach to the specialty of open reduction. If one is not prepared to carry out each of the various steps to preserve the patient before and after surgery, then the surgeon should follow some less exacting form of care. 100% restoration to form and function, although ideal, is not always safe. A compromise is frequently justified in the best interests of

the patient. Illustrations are unfortunately offered which violate the originators' plans of pin insertion and specific premises. The authors should emphasize more strongly that one should study each piece of apparatus sufficiently so that it is applied as the original inventor expert intended its use. These authors claim many benefits for open surgery, so as to better preserve the whole patient. This small volume will strengthen the hand of the newer and older surgeon alike.

JOHN W. COOPER, M.D.

Handbook of Poisoning: Diagnosis and Treatment, 2d Ed.

By Robert H. Dreisbach, M.D., Ph.D., 474 pp., $3.50, Lange Medical Publications, 1959.

This inexpensive handbook is highly recommended for physicians who come in contact with poison cases. Our complex civilization exposes everyone to various hazards with the introduction of more and more chemicals to industrial, agricultural, and domestic processes. It behooves the practitioner to keep well informed and serve as a liaison for informing the general public on poisons.

The author presents a handy reference which is clear and concise for the purpose of the practicing physician. Brand names are referred to in the index for easy usage.

Emergency procedures are well outlined. The section on fishes and insects is interesting. The author refers to at least 50 to 100 cases of fish poisoning reported annually in Hawaii.

RICHARD K. B. HO, M.D.

Christopher's Minor Surgery, 8th Ed.

Edited by Alton Ochsner, M.D., F.A.C.S., and Michael E. DeBakey, M.D., F.A.C.S., 539 pp., $10.50, W. B. Saunders Co., 1959.

It was with pleasure and anticipation that I accepted the offer to review the eighth edition of "Christopher's Minor Surgery." I have a copy of the first edition dated November 11, 1930. I had read that edition avidly from cover to cover and have always felt it was an excellent book. Through the years, I have often turned to it for assistance.

The new edition is attractively printed and bound. It is edited by Ochsner and DeBakey. Each chapter is written by an authority. My first impression was that the book had lost some of its purpose and interest, but on careful consideration I find that, aside from some duplication of material, it covers the subject well and should be a valuable adjunct to any surgically minded doctor's library. This is not the old Christopher but Ochsner and Debakey, truly another book.

DOUGLAS B. BELL, M.D.

Physiology of Spinal Anesthesia

By Nicholas M. Greene, B.S., M.A., M.D., 195 pp., $6.00, The Williams and Wilkins Company, 1958.

This is an excellent monograph to have in the County Library even though I cannot see too much usefulness for the private library of the surgeon or anesthesiologist. It stays strictly to the title subject and in a very thorough way summarizes and quotes from all the significant research and clinical reports up to this time.

Because of the extensive use of quotation and reference notation, I found the text difficult to read and poorly suited to a rapid reading, though of course this same feature adds to its usefulness as a reference work. The most readable chapter deals with "Obstetrical Physiology," and this I recommend to all obstetricians, whether they utilize spinal anesthesia or not in their deliveries, for it is a concise account of physiological changes occurring during pregnancy, which have great bearing on the welfare of mother and child no matter what the anesthetic choice might be.

In general I might summarize the major findings of the subject by saying that with the exception of altered conduction and function of nerve tissue in contact with the drugs used in the spinal anesthetic, the physiological alterations throughout the body and its organ systems depend upon the pre-ganglionic sympathetic blockade produced by the anesthesia.

CARL E. JOHNSEN, JR., M.D.

Bone Tumors, 2d Ed.

By Louis Lichtenstein, M.D., 402 pages, $12.00, C. V. Mosby Co., 1959.

The majority of the chapters on Bone Tumors in this second edition are duplications of those in the first edition, written seven years ago. Nevertheless, it will continue to prove useful to orthopedists as well as to radiologists and pathologists interested in osseous lesions. A chapter on "Tumors of Periosteal Origin" has been introduced, and a discussion of "Tumors of Synovial Joints, Bursae, and Tendon Sheaths" has been added to the appendix as collateral materials.

This book will continue to be a popular text on bone tumors, lending itself to easy reading and reference.

EDMUND LUM, M.D.

Urology, Vols. I, II, III

Edited by Meredith Campbell, M.S., M.D., F.A.C.S., pp. 2356, $60.00, W. B. Saunders Co., 1954.

It would be difficult to criticize this exhaustive, detailed, and most complete work encompassing the entire field of urology, written by a panel of internationally known experts and edited by one of the famous pioneers in this specialty. Every practicing urologist is familiar with this great work as the standard reference source of today in the field of genitourinary surgery. It is too detailed, too voluminous, and too expensive to be recommended for purchase by any but those specializing in urology, but without question it should be the basis of every urologist's professional library.

W. S. STRODE, M.D.

★Leukemia

By William Dameshek, M.D., and Frederick Gunz, M.D., 420 pp., $15.75, Grune & Stratton, 1958.

Excellent review of the whole subject of leukemia. This book would be of interest to the investigator as well as the clinician. Highly recommended to those interested in the problem of leukemia.

ROBERT T. S. JIM, M.D.

Gynecologic Radiography

By Jean Dalsace, M.D., and J. Garcia-Calderon, M.D., 188 pp., $8.00, Paul B. Hoeber, Inc., 1959.

This comprehensive and useful atlas of hysterosalpingography and x-ray studies of the breasts will be especially useful to gynecologists and radiologists. It includes chapters on conduct of the examination; normal and abnormal anatomy of the uterus and tubes; uterine perforations; cervix uteri; obstruction and stenosis of

(Continued on page 586)

(Continued from page 585)

the fallopian tubes; tuberculosis; cancer; cysts; fistulas; pregnancy; foreign bodies; double contrast radiograms and sources of error. There are over 300 excellent illustrations of confirmed cases.

The techniques of radiography of the mammary glands without preparation or with injection of the contrast media (mammography) occupies the last chapter of this book. The technique of both types of examination is given and shown with illustrations. Diagnosis by this type of examination is hazardous except after long experience and can be a common source of error. This I do not recommend as a common procedure over the existing methods. The book is well written and will be an asset to our reference library and in the library of gynecologists and radiologists.

PETER J. WASHKO, M.D.

The Medical Management of Cancer

By Henry D. Diamond, M.D., F.A.C.P., 179 pp., $6.75, Grune & Stratton, 1958.

This book, although written for internists, will be of interest to all physicians who treat cancer patients by nonsurgical methods. It is recommended especially to oncologists, pediatricians, and general practitioners as well as specialists in internal medicine.

There are two main divisions. The first deals with those types of cancer in which medical treatment is the primary form of therapy. The second part concerns itself with the medical treatment of cancers which, after definitive surgery, have recurred or spread; and those which were inoperable by virtue of being widely disseminated at the time of original examination of the patient and, therefore, are no longer considered prospects for curative surgical procedures. This book offers the physician some new ways of treating the hopeless cancer patient.

The sections dealing with the treatment of leukemia and advanced breast cancer are especially good. The illustrative pictures are well done, and the book is generously illustrated with over 40 figures and 23 tables. This book is easy to read and very brief (151 pages) compared with most dealing with the treatment of cancer.

WALTER B. QUISENBERRY, M.D.

Clinical Auscultation of the Heart, 2d Ed.

By Samuel A. Levine, M.D., Sc.D. (Hon.), F.A.C.P., and W. Proctor Harvey, M.D., 657 pp., $11.00, W. B. Saunders Co., 1959.

This current volume represents a significant expansion of the senior author's work a decade ago. The text reads easily in most areas and illustrations are plentiful. This should serve as a useful text as a reference source, indicating fully and well the accuracy and usefulness of basic clinical examination in the diagnosis of heart disease.

BERNARD J. B. YIM, M.D.

Psychoanalysis of Today

By S. Nacht, M.D., pp. 228, Grune & Stratton, 1959.

This collection of articles on psychoanalytic subjects is of interest primarily to psychiatrists, although others may find rewards in reading certain sections of the book.

Representing current psychoanalytic thinking in France, there are papers on the indications for psychoanalysis, the vicissitudes of such treatment of various clinical syndromes, the psychoanalysis of children, and others.

The chapter by Dr. Nacht entitled "Psychoanalytic Therapy" is a succinct and understandable outline of the method and goals of psychoanalysis, and may help nonpsychiatrist readers to understand better its therapeutic rationale. Likewise the section entitled "Psychoanalysis and Medicine" by R. Held is a fascinating account, with many illustrative cases, of the clinical effects of the attitudinal interactions between psychiatrists and other physicians.

KENNETH H. RUSCH, M.D.

The Foot and Ankle, 4th Ed.

By Philip Lewin, M.D., F.A.C.S., F.L.C.S., 612 pp., $14.00, Lea & Febiger, 1959.

This is a revised edition of Dr. Lewin's semi-encyclopedic efforts to emulate Dr. Kanavel's monumental work on the hand.

There are very few original contributions from the author. He has collected and summarized some of the recent articles concerning the pathomechanics and treatment of foot disorders. Unfortunately, these condensed contributions by other authors are included in the text without any evaluation, and are often scattered throughout the book without regard to context. Dr. Lewin's manner of writing is usually pedantic, but there is a great variation in style which furthers the disorganized feeling one gets from the book.

Despite the literary drawbacks, *The Foot and Ankle* is a useful sourcebook and ready reference concerning foot problems and would appear to be worthwhile for a nonspecialist's use.

The author's opinions cover a few subjects not elsewhere represented and therefore should be read casually by the specialist: e.g., the problems of a ballet dancer's feet!

That portion dealing with the ankle is quite inadequate when compared to other works such as that by J. Grant Bonnin.

ROWLIN L. LICHTER, M.D.

Also Received

The Surgical Clinics of North America, Vol. 39, No. 6

Consulting Editors Conrad Lam, M.D., and Harry C. Saltzstein, M.D., pp. 1,467-1,770, W. B. Saunders Co., December, 1959.

The Detroit number contains two symposia. One is on the armamentarium of the surgeon and deals mainly with instruments, apparatus, and materials in the development of which the surgeons of the Henry Ford Hospital have made contributions. The other presents the broad spectrum of pre-and postoperative care available today.

Clinical Psychopathology

By Kurt Schneider, Prof., 171 pp., $4.50, Grune & Stratton, Inc., 1959.

For psychiatrists only.

Smoking and Health

By Alton Ochsner, M.D., 108 pp., $3.00, Julian Messner, Inc., 1959.

A frightening little volume,—but it would have been more frightening if the author hadn't been convinced about the answer before he wrote it.

The Medical Clinics of North America, Vol. 43, No. 6

David M. Davis, M.D., Guest Editor, pp. 1569-1841, W. B. Saunders Company, November, 1959.

A nationwide symposium on commonly mismanaged urologic problems.

Pediatric Clinics of North America, Vol. 6, No. 4

C. Everett Koop, M.D., Consulting Editor, pp. 943-1295, W. B. Saunders Company, November, 1959.

A symposium on pediatric surgery.

★ Work and the Heart

Edited by Francis F. Rosenbaum, M.D., and Elston L. Belknap, M.D., 537 pp., $12.00, Paul B. Hoeber, Inc., 1959.

Cardiologists will find this collection of 57 articles and some panel discussions just about indispensable.

Neurology of Infancy

By Anatole Dekaban, M.D., Ph.D., 388 pp., $12.00, Williams & Wilkins Co., 1959.

An invaluable and authoritative reference work for pediatricians, neurologists, and neurosurgeons particularly.

★ Master Your Tensions and Enjoy Living Again

By George S. Stevenson, M.D., and Harry Milt, 241 pp., $4.95, Prentice Hall, 1959.

A wise and practical guide to saner, happier living. You can recommend it to many patients.

Acute Pericarditis

By David H. Spodick, M.D., 182 pp., $6.50, Grune & Stratton, 1959.

For cardiologists—or just plain doctors who need to know more about pericarditis. The author is a well known Boston cardiologist.

Relaxation and Exercise for Natural Childbirth, 2d Ed.

By Helen Heardman, 31 pp., $ .75, E. & S. Livingstone, Ltd., 1959.

This 31-page pamphlet, though written in English, would be intelligible to American patients too. Each obstetrician should pass on its contents individually, however.

Diseases of the Nervous System, 9th Ed.

By Sir Francis Walshe, M.D., D.Sc., F.R.S., 373 pp., $8.00, The Williams & Wilkins Co., 1959.

A textbook, said to be for practitioners and students, but really for students and practitioners. Leprosy is not mentioned under the peripheral neuritides nor in the index.

Synopsis of Gynecology, 5th Ed.

By Robert James Crosse, M.D., Daniel Winston Bleacham, M.D., & Woodward Beacham, M.D., 340 pp., $6.50, The C. V. Mosby Co., 1959.

The fifth edition in 27 years and the first since 1946. Compact and practical; 106 illustrations. Pocket size.

Medical Management of the Menopause

By Minnie B. Goldberg, M.D., 98 pp., $4.50, Grune & Stratton, 1959.

An authoritative, sympathetic, and practical little volume by a San Francisco internist-endocrinologist.

★ Schifferes' Family Medical Encyclopedia

By Justus J. Schifferes, Ph.D., 617 pp., $ .50, Perman Books, 1959.

The biggest fifty cents worth of book we ever saw. You can recommend it without hesitation. Available in hard covers at $4.95 from Little, Brown & Co.

★Upper Digestive Tract, Part I, Vol. 3

By Frank H. Netter, M.D., 206 pp., $12.50, Ciba, 1959.

What Spalteholz did for gross anatomy, Dr. Netter does for gross pathology. Beautifully done. Sold at cost.

★A Cookbook for Diabetics

By Deaconess Maude Behrman, 171 pp., $1.00, American Diabetes Association, 1959.

Just as advertised. A useful volume for the housewife with a diabetic in the home.

Where Somebody Cares

By Mother M. Bernadette De Lourdes, O. Carm., 252 pp., $5.00, G. P. Putnam's Sons, 1959.

The Mary Walsh Manning home for the aged is described in loving detail.

The Megaloblastic Anemias

By Victor Herbert, M.D., 162 pp., $6.00, Grune & Stratton, 1959.

There are 612 references and a detailed index. Hematologists and internists would find this a most useful reference text.

High Arterial Pressure

By F. H. Smirk, M.D., 700 pp., $15.00, Charles C. Thomas, 1957.

A detailed consideration of both theoretical and practical aspects of arterial hypertension. Valuable as a reference work, and, considering its size and scope, very modestly priced.

Behavioral Change in the Clinic—A Systematic Approach

By Gerald R. Pascal, Ph.D., 128 pp., $4.75, Grune & Stratton, 1959.

A scientific look at psychotherapy, by a psychologist. Good, but deep.

Mycoses of Man and Animals

By R. Vanbreuseghem, M.D., 235 pp., $10.50, Charles C. Thomas, 1958.

This excellent book would have filled a gap, if there had been a gap.

(Continued on page 588)

BOOK REVIEWS

(Continued from page 587)

The Fluids of Parenteral Body Cavities

By Paul D. Hoeprich, M.D., and John R. Ward, M.D., $4.75, 98 pp., Grune & Stratton, 1959.

The mesenchymal spaces come in for joint attention, with useful results.

Ciba Foundation Symposium on the Regulation of Cell Metabolism

By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc., 387 pp., $9.50, Little, Brown & Co., 1958.

and

Ciba Foundation Symposium on Carcinogenesis: Mechanisms of Action

By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., 335 pp., $9.50, Little, Brown & Co., 1958.

More about these important but esoteric subjects than the average physician wants to know or would be able to absorb. Done with Ciba's ususal care and skill.

Ciba Foundation Study Group No. 2

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc. 115 pp., $2.50, Little, Brown & Co., 1959.

Enzyme chemistry—significant, vitally important, and alarmingly obscure. DPN means diphosphopyindine nucleotide. Ciba has done it again.

Ciba Foundation Study Group No. 1

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A., 120 pp., $2.50, Little, Brown & Co., 1959.

Neurologists and dermatologists will find this 117-page volume fascinating, though Weddell's work may require some of it to be rewritten.

★Doctors and Patients

Edited by Noah D. Fabricant, M.D., 204 pp., $5.25, Grune & Stratton, Inc., 1959.

Personal-experience accounts by 31 articulate physicians, most of them well known. Fascinating, for the most part.

Progress in Neurology and Psychiatry, Vol. XIV

Edited by E. A. Spiegel, M.D., 656 pp., $12.00, Grune & Stratton, 1959.

An annual review volume of great importance to neurologists, neurosurgeons and psychiatrists.

★ Atlas of Clinical Endocrinology

By H. Lisser, A.B., M.D., and Roberto F. Escamilla, A.B., M.D., 476 pp., $18.75, The C. V. Mosby Co., 1957.

Two San Francisco internist-endocrinologists have compiled this orderly and beautifully illustrated atlas of 63 endocrine disorders, with 139 plates containing perhaps 600 illustrations. A good buy.

Elementary Statistics

By Frederick E. Croxton, Ph.D., 376 pp., $1.95, Dover Publications, Inc., 1959.

Another book to help you not to be fooled by figures. Nice large type.

★ Symposium on Glaucoma

Edited by William B. Clark, M.D., F.A.C.S., 314 pp., $13.50, The C. V. Mosby Co., 1959.

Six American eye-clinicians and two eye-pathologists have contributed 22 articles on glaucoma, from anatomy to therapy, with 100 illustrations and 65 pages of round table discussions.

Psychopathy

By Carl Frankenstein, Ph.D., 198 pp., $6.75, Grune & Stratton, 1959.

For psychiatrists mainly.

Heroic Sanctity and Insanity

By Thomas Verner Moore, M.D., 243 pp., $5.00, Grune & Stratton, 1959.

The author, a priest and a psychiatrist, believes that sanctity "or even a moderate degree of holiness" may prevent paresis, and probably other mental disturbances as well.

Practical Psychiatry for Industrial Physicians

By W. Donald Ross, M.D., B.Sc. (Med.), E.R.C.P.(C), 401 pp., $7.50, Charles C. Thomas, 1956.

Two reviewers have been unable to review this book. Evidently it is a reference volume.

★ A Guide to Antibiotic Therapy

By Henry Welch, Ph.D., 69 pp., $3.00, Medical Encyclopedia, Inc., 1959.

Too detailed for ordinary reference—but if you have a problem case, don't miss this excellent reference work. All in tables, with a two-page spread for each antibiotic.

★ Pyelonephritis

By Fletcher H. Colby, M.D., $7.50, 214 pp., The Williams & Wilkins Co., 1959.

Ninety-five illustrations, diagrams, and a good index help make this a valuable book to have around.

Trifluoperazine

By John H. Moyer, M.D., 191 pp., $3.50, Lea & Febiger, 1959.

Trifluoperazine is Stelazine — the tranquilizer that keeps you feeling brisk.

★ The Physician and the Law, 2d Ed.

By Rowland H. Long, 302 pp., $5.95, Appleton-Century-Crofts, Inc., 1959.

If you do any court work you need this—it is *packed* with helpful information.

Your Mind Can Make You Sick or Well

By Curt S. Wachtel, M.D., 244 pp., $4.95, Prentice Hall, 1959.

Aimed at patients—and it might strike some just right.

(Continued on page 592)

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From a Large Midwestern University: FUROXONE Controls Antibiotic-Resistant Outbreak. An outbreak of bacillary dysentery due to Shigella sonnei was successfully controlled with FUROXONE after a broad-spectrum antibiotic had proved inadequate. Cure rates (verified by stool culture) were 87% with FUROXONE, 36% with chloramphenicol. Only FUROXONE "failures" were those lost to follow-up. Chloramphenicol failures subsequently treated with FUROXONE responded without exception. FUROXONE was also used effectively as prophylaxis and to eliminate the carrier state. It was "extremely well tolerated in all 191 individuals who received it either prophylactically or therapeutically."

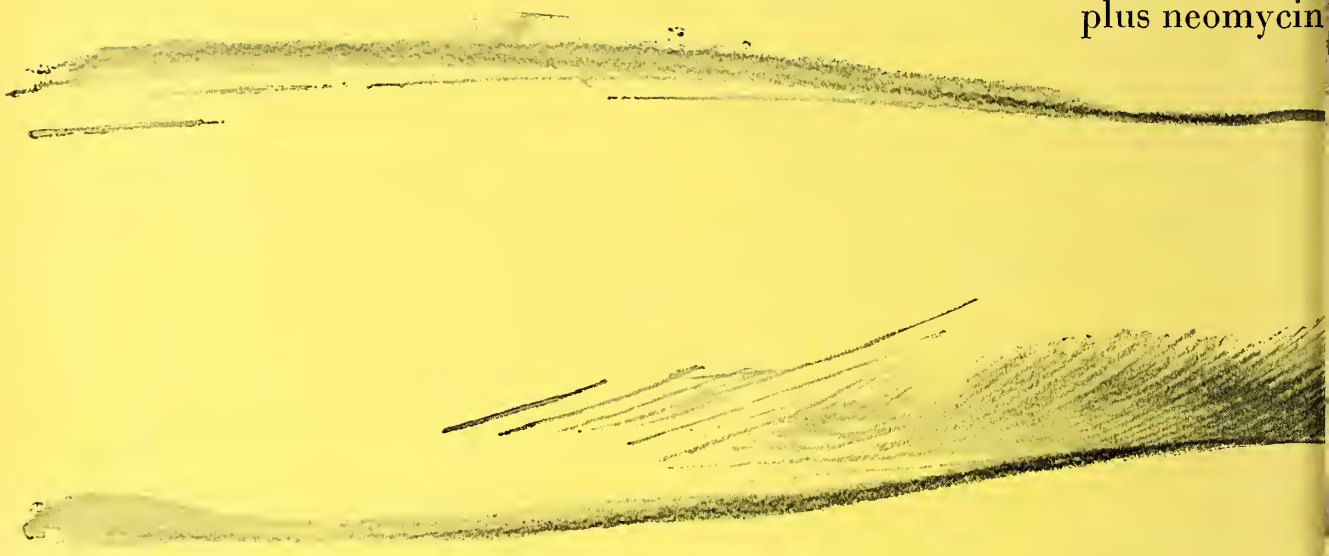
Galeota, W.R., and Moranville., B.A.: Student Medicine (in press)

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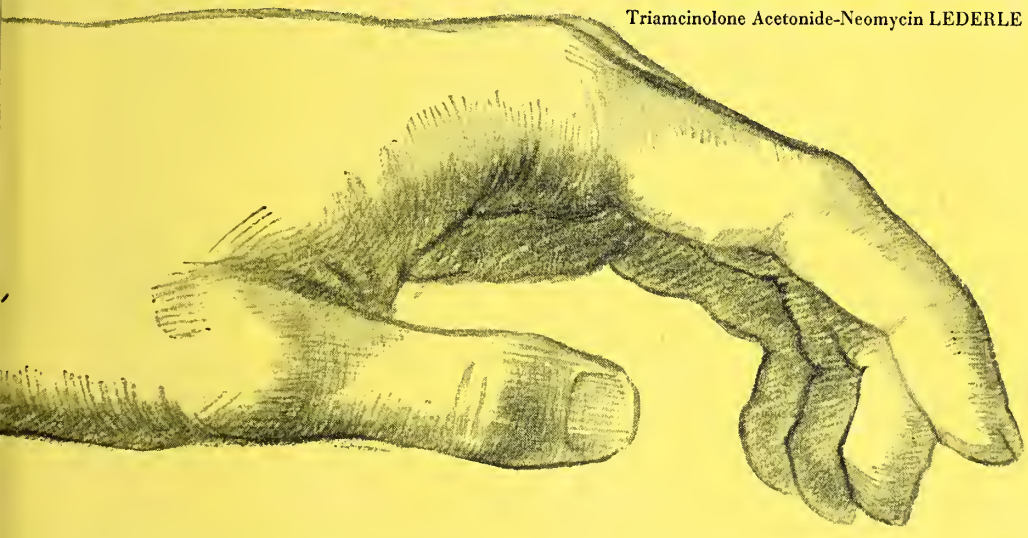
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References: 1. Kanof, N. B., and Blau, S.: *New York J. Med.* 59:2184 (June 1) 1959.
2. Smith, J. G., Jr.; Zawisza, R. J., and Blank, H.: *A.M.A. Arch. Dermat.* 78:643 (Nov.) 1958.

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BOOK REVIEWS

(Continued from page 588)

The Practice of Clinical Child Psychology

By Alan O. Ross, Ph.D., 275 pp., $5.75, Grune & Stratton, 1959.

For psychiatrists and pediatricians. Mostly in English, with only occasional lapses into psychiatrese.

★Antibiotic Therapy for Staphylococcal Diseases

Edited by Henry Welch, Ph.D., and Felix Marti-Ibanez, M.D., 208 pp., $4.50, Medical Encyclopedia, Inc., 1959.

More about this important topic than most doctors can afford to take the time to learn. Valuable reference work.

Countertransference

By Benjamin Wolstein, Ph.D., 179 pp., $5.50, Grune & Stratton, 1959.

For psychiatrists only.

★A Way of Life

By Sir William Osler, 278 pp., $1.50, Dover Publications, Inc., 1959.

A great big bargain. Give it to any boy you know who might be interested in medicine. Buy it for yourself, too!

Leukocyte Antigens and Antibodies

By Roy L. Walford, M.D., 182 pp., $6.75, Grune & Stratton, 1960.

There are 567 references. Pretty deep for the average physician.

★Encyclopedia of Medical Syndromes

By Robert H. Durham, M.D., F.A.C.P., 628 pp., $13.50, Paul B. Hoeber, Inc. 1960.

Indispensable reference work for medical writers. Each syndrome is described in some detail, with cross-references by systems and references to the literature.

Clinical Obstetrics and Gynecology

Edited by S. B. Gusberg, M.D., and Edwin J. De Costa, M.D., pp. 929-1228, Paul B. Hoeber, Inc., December, 1959.

This edition consists of two symposia; one on the advances in genecologic surgery and the other on cesarean section.

The Medical Clinics of North America, Vol. 44, No. 1

Guest Editor Joseph B. Kirsner, M.D., pp. 1-296, W. B. Saunders Company, January, 1960.

Forty-two authors selected from the medical teaching institutions of Chicago discuss diagnosis of incipient disease.

British Medical Bulletin, Vol. 16, No. 1

Lawrence P. Garrod, Scientific Editor, pp. 1-88, January, 1960.

A symposium on antibiotics in medicine.

HAWAII MEDICAL ASSOCIATION

(Continued from page 552)

BUDGET

A discussion on the various allotments for the 1960 budget included questions on the allotment to the Legislative Committee. It was explained that this was the same as their last year's allotment except that it all came from general revenues. Dr. Cushnie said the reason an increase in dues had been voted in 1957 was because the Association had run on a deficit budget for several years. The JOURNAL budget was discussed and it was explained that budgeted operating expenses are arbitrarily prorated to the JOURNAL and the profit figure for the JOURNAL reflects these prorations. In order to balance the expenditures, these prorated figures are subtracted from the total budget allotments. Dr. Cushnie thought the prorations should be watched carefully and re-examined every year.

ACTION:

It was voted to adopt the budget.

OAHU HEALTH COUNCIL SURVEY

Dr. Allison gave the background of the survey which will cover all the islands. It is being made by Dr. Hiscock with funds made available by the Public Health Committee of the Chamber of Commerce of Honolulu. The Association is being asked to list the greatest strengths and weaknesses of the public health program in Hawaii. The strengths mentioned were nursing care, cytology laboratory, and mass inoculations. Weaknesses mentioned were the willingness of the Department of Health to institute new programs and unwillingness to improve programs already started such as the government physician drug deal. Lack of control of the child health clinics which are not confined to the indigent, limiting the time of the physician to the point he cannot do the job he should.

ACTION:

It was voted to give Dr. Hiscock permission to write the members of the Association to get their opinions.

NOMINATING COMMITTEE

Dr. Nishigaya asked Dr. A. Y. Wong and Dr. W. N. Bergin to serve on the Nominating Committee. He reminded the Maui County members that the next president-elect will be from Maui.

A. H. ROBINS AWARD

Dr. Nishigaya advised that the Association had received a letter from Robins dated January 27 which asked for approval of an award they are considering which would be presented to the physician of the year as selected by the Association at their annual meeting.

ACTION:

It was voted to approve of this project.

BOARD OF GOVERNORS' MINUTES

Dr. Allison said he felt that the Council members should be completely aware of what is going on at the county board meetings and suggested that the individual counties be asked to provide the minutes of their board meetings. In Honolulu they would be the minutes of the Board of Governors. A discussion followed on how this information could best be disseminated but no definitive action was taken. Dr. Nishigaya asked that a copy of the Board of Governors minutes be sent to Dr. Allison.

The meeting adjourned at 10:40 p.m.

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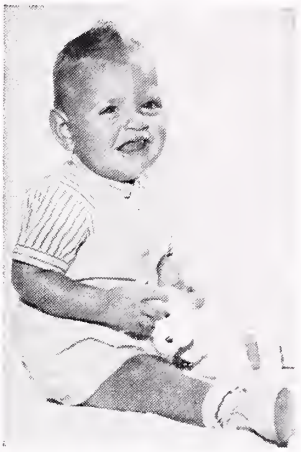
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Ames Company, Inc.	494, 595
Ayerst Laboratories	504
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*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

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Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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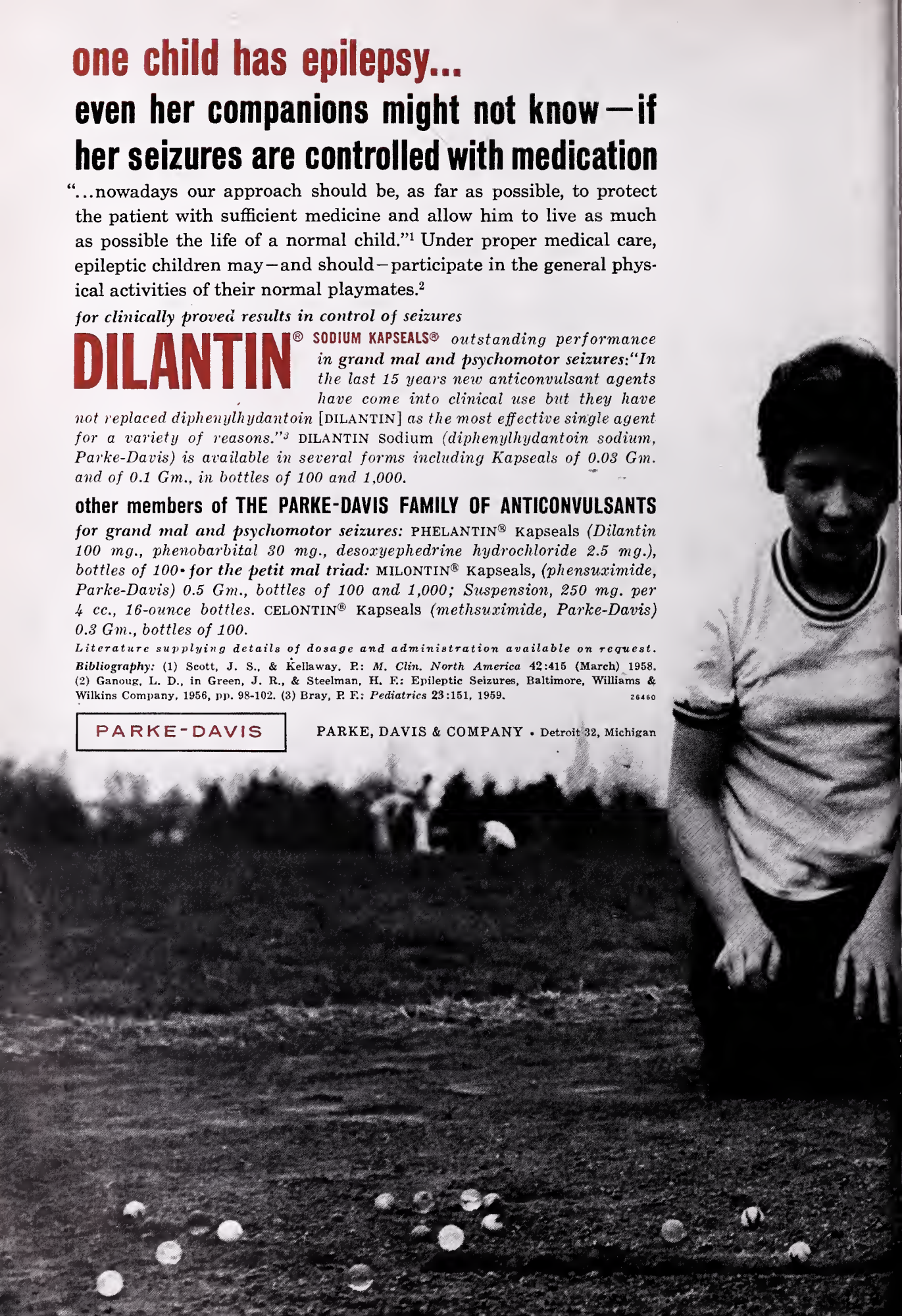
Literature supplying details of dosage and administration available on request.

Bibliography: (1) Scott, J. S., & Kellaway, P.: *M. Clin. North America* 42:415 (March) 1958. (2) Ganoug, L. D., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, pp. 98-102. (3) Bray, P. F.: *Pediatrics* 23:151, 1959.

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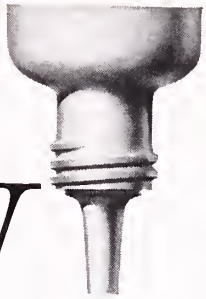
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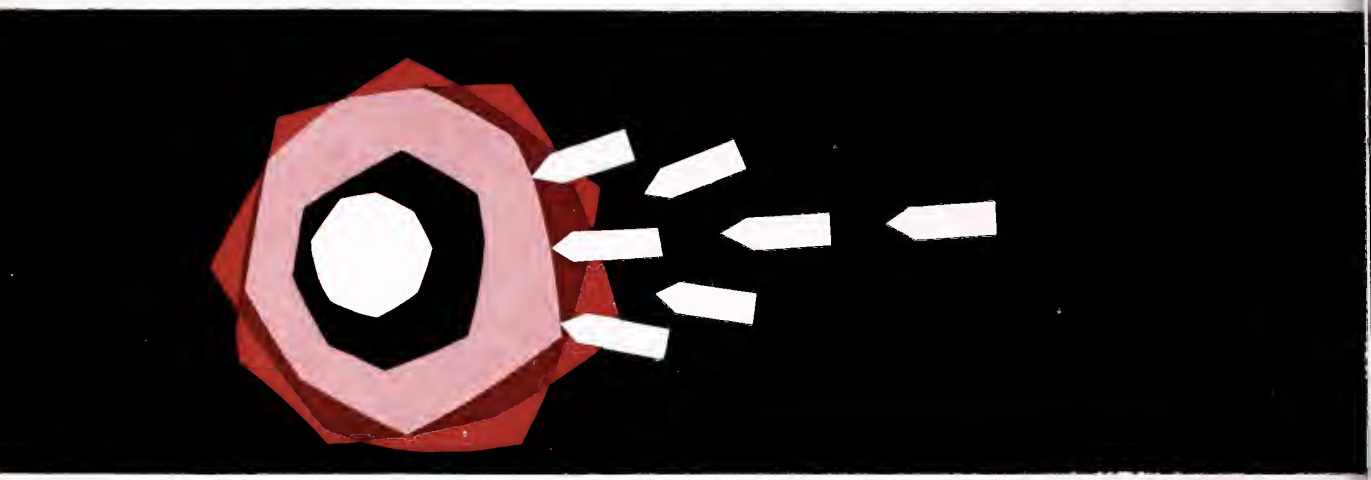
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references: (1) Clinical Research Division, Mead Johnson & Company. (2) Howell, C. M., Jr.: Evaluation of Methdilazine Hydrochloride as an Antipruritic Agent, North Carolina M. J. *21* (May) 1960 (in press). (3) Wahner, H. W., and Peters, C. A.: An Evaluation of Some Newer Antihistaminic Drugs Against Pollinosis, Proc. Staff Meet. Mayo Clin. *35*:161-169 (March 30) 1960.

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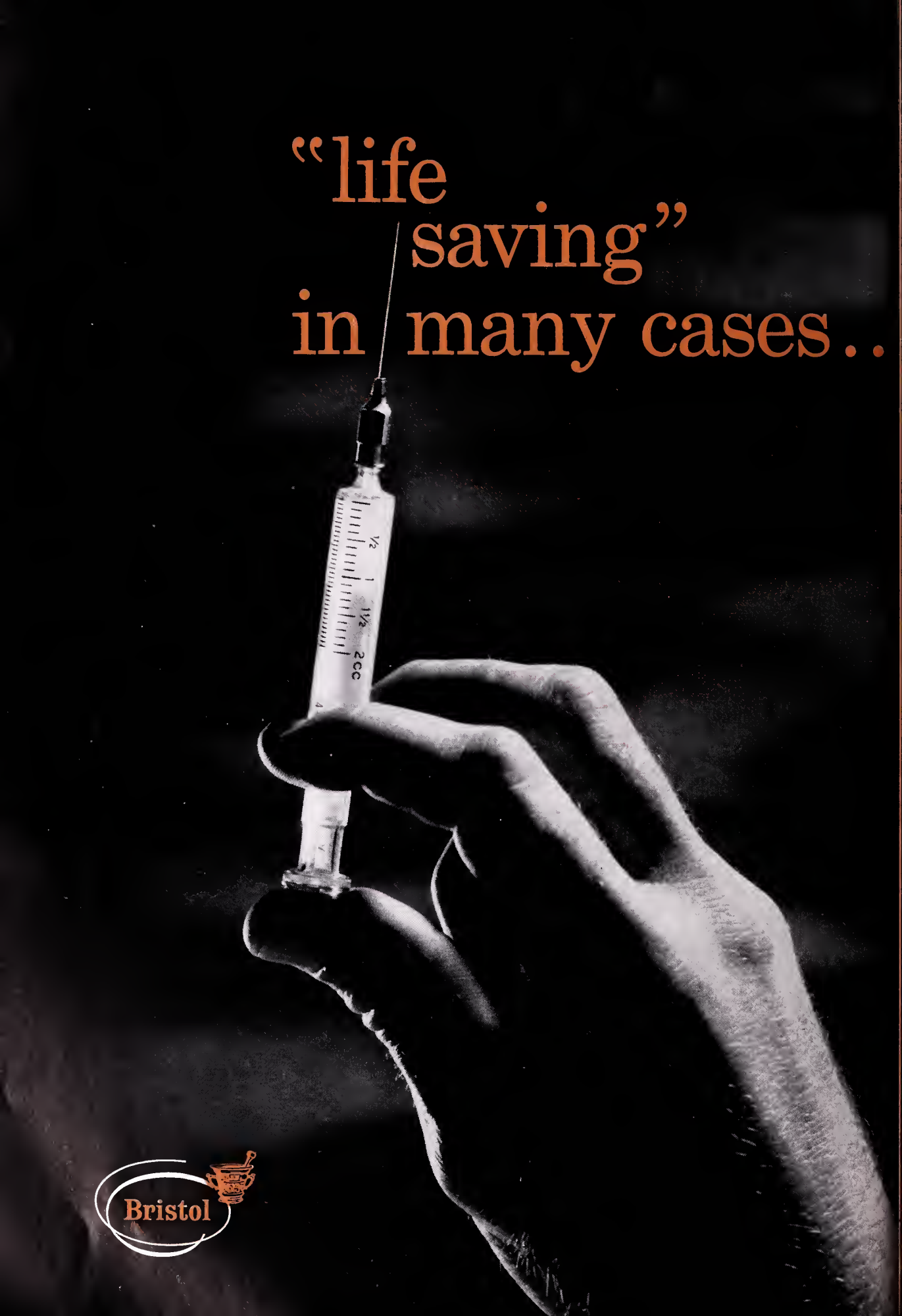
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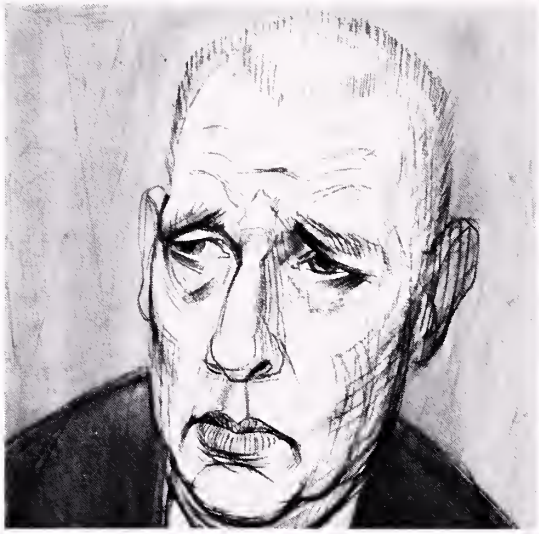
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REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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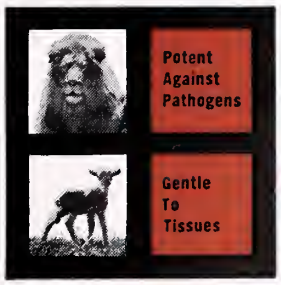
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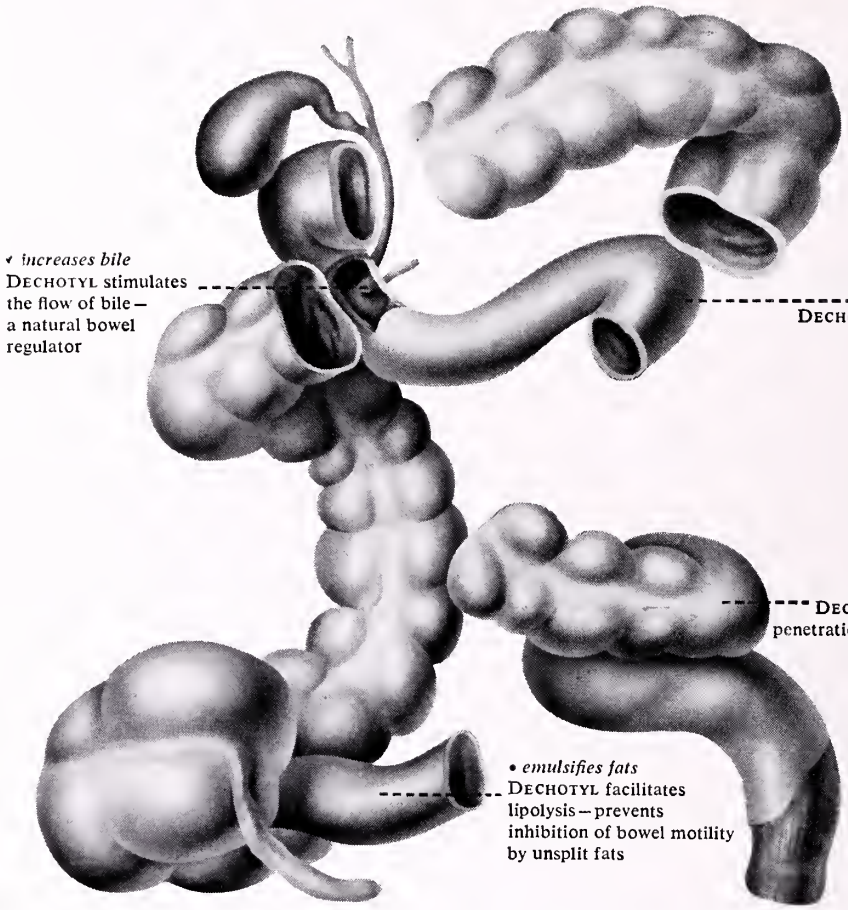
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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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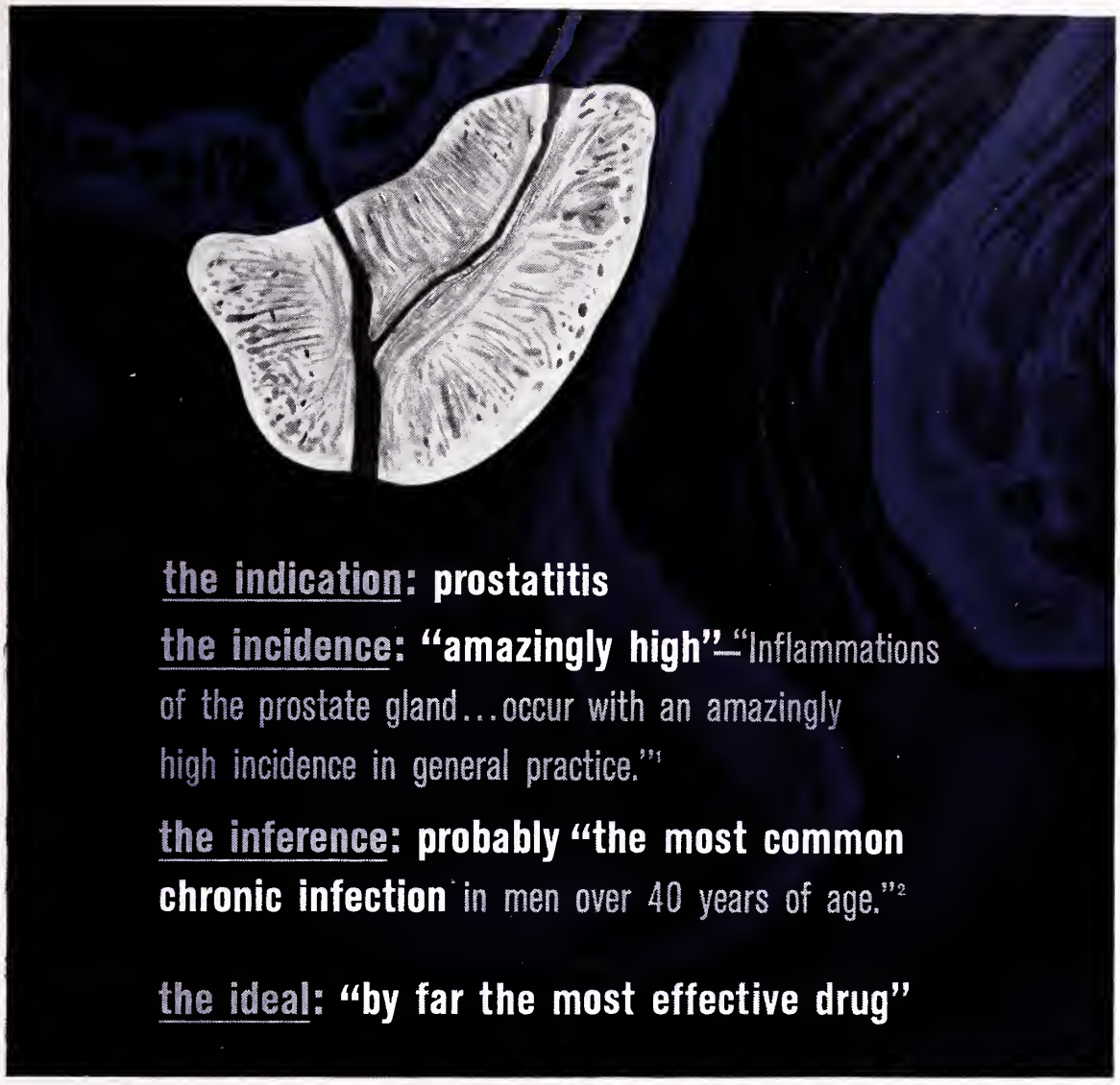
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the inference: probably "the most common chronic infection in men over 40 years of age."[2]

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References: 1. Campbell, M. F.: Principles of Urology, Philadelphia, W. B. Saunders Co., 1957. 2. Farman, F., and McDonald, D. F.: Brit. J. Urol. **31**:176, 1959. 3. Sanjurjo, L. A.: Med. Clin. N. America **43**:1601, 1959.

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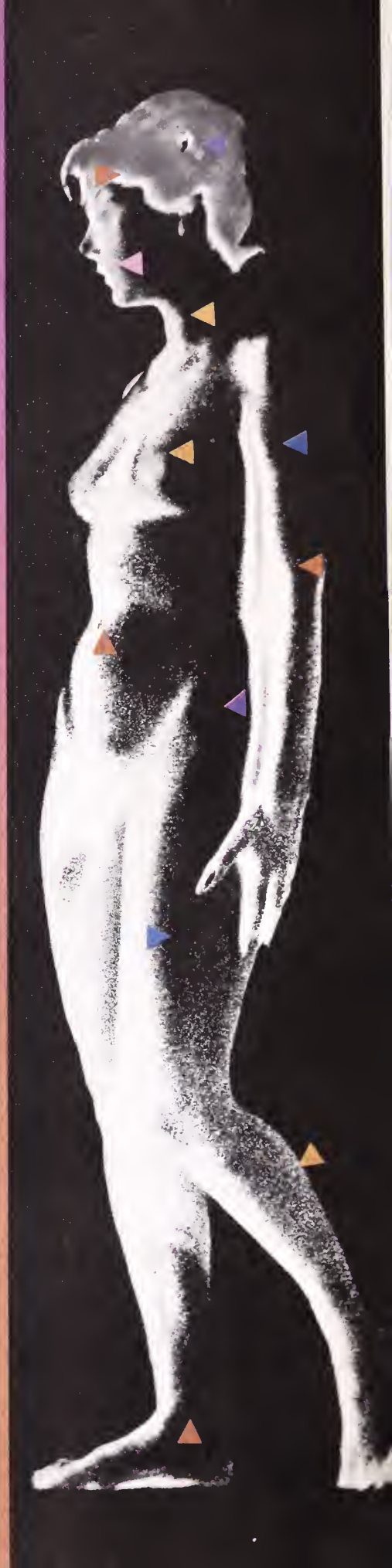
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arthralgias
myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
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tension headache
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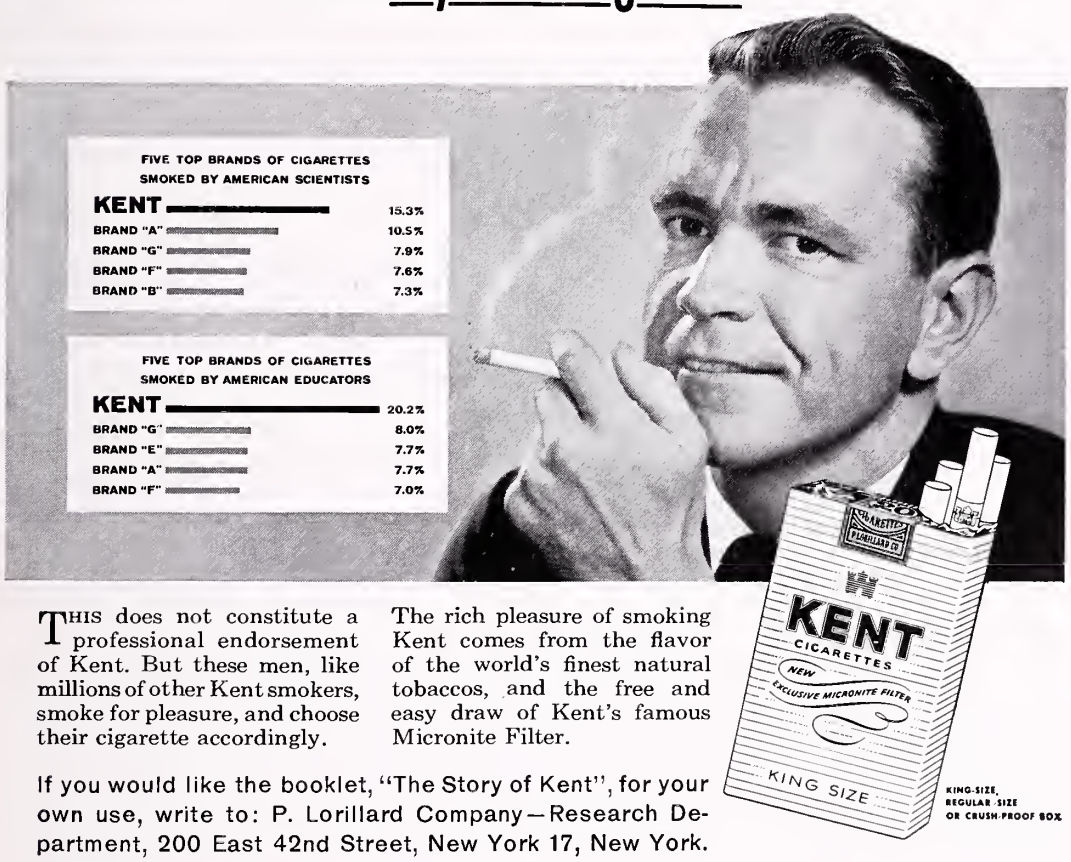


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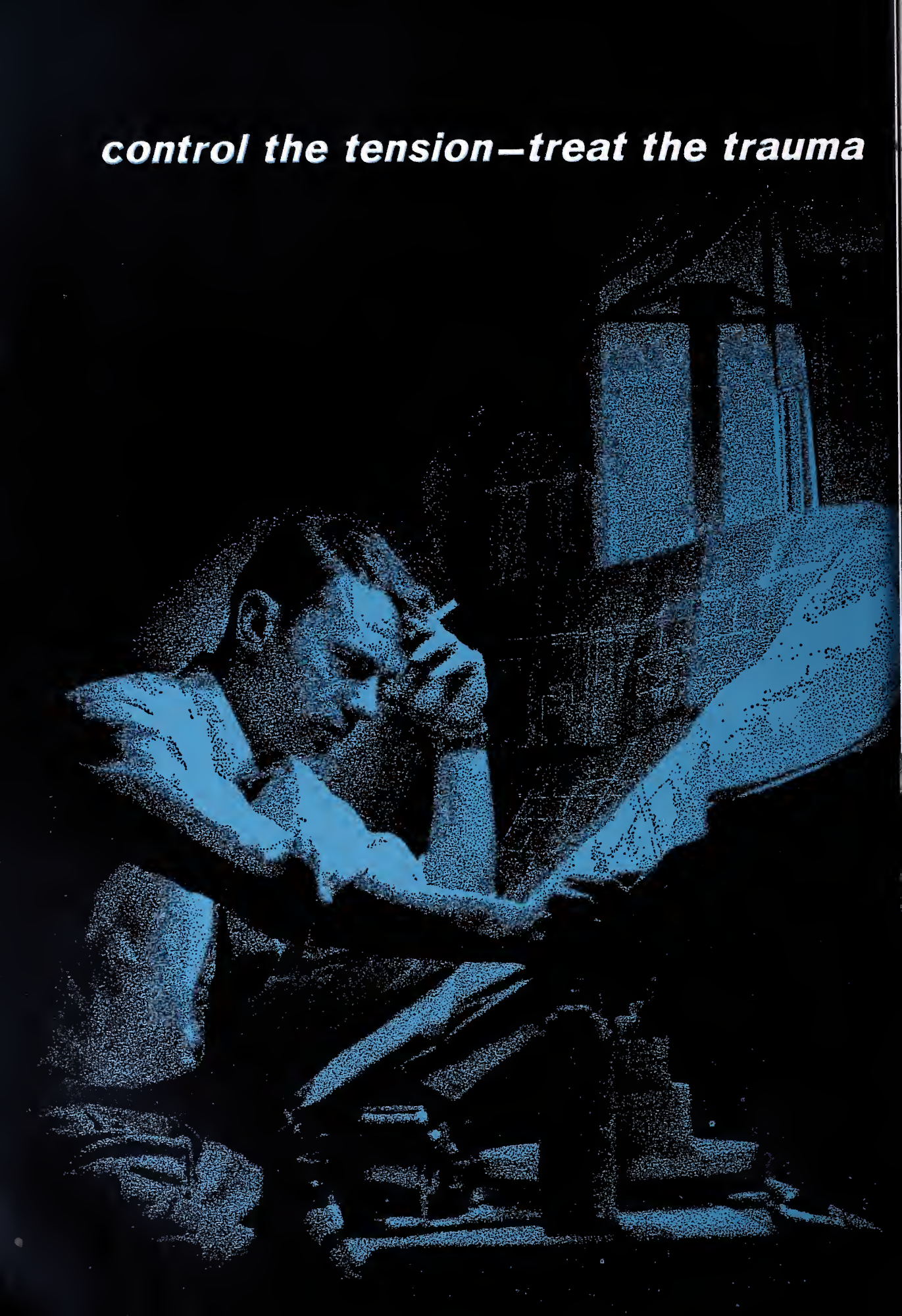
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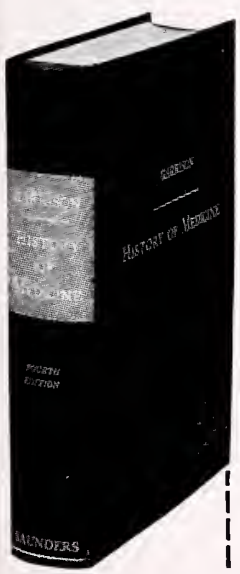
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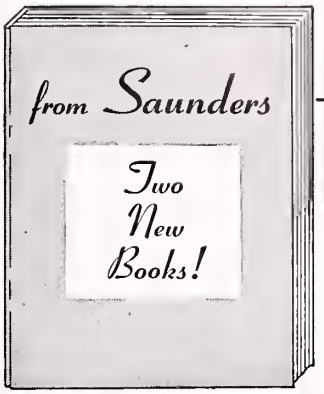
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*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. 2/2830MS





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*Adams, L. D.: The Commonsense Book of Wine, New York, David McKay Company, Inc., 1958, pp. 162-163.

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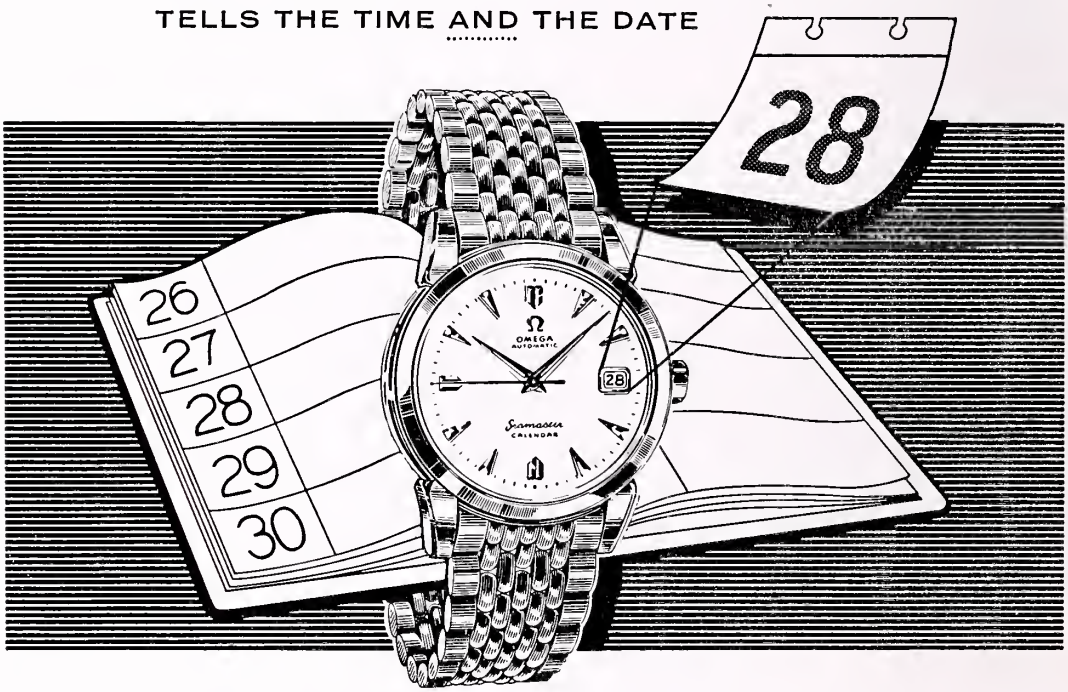
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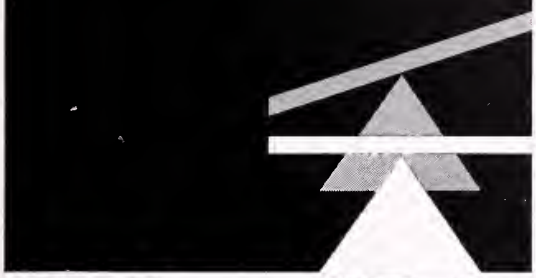
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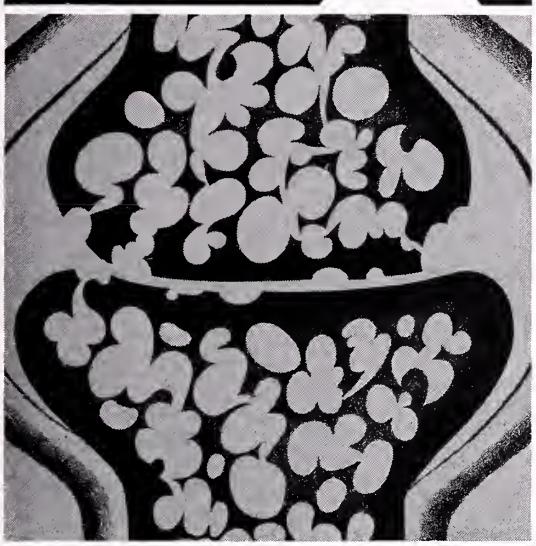
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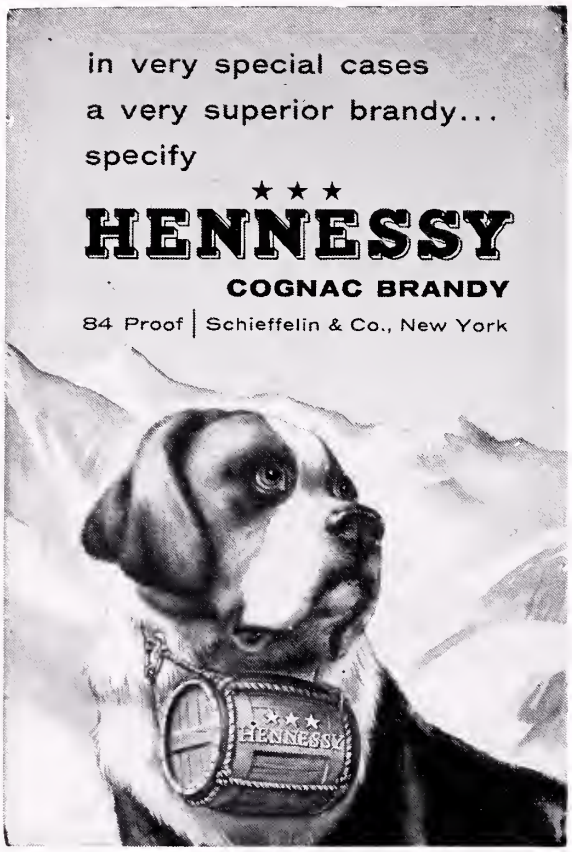
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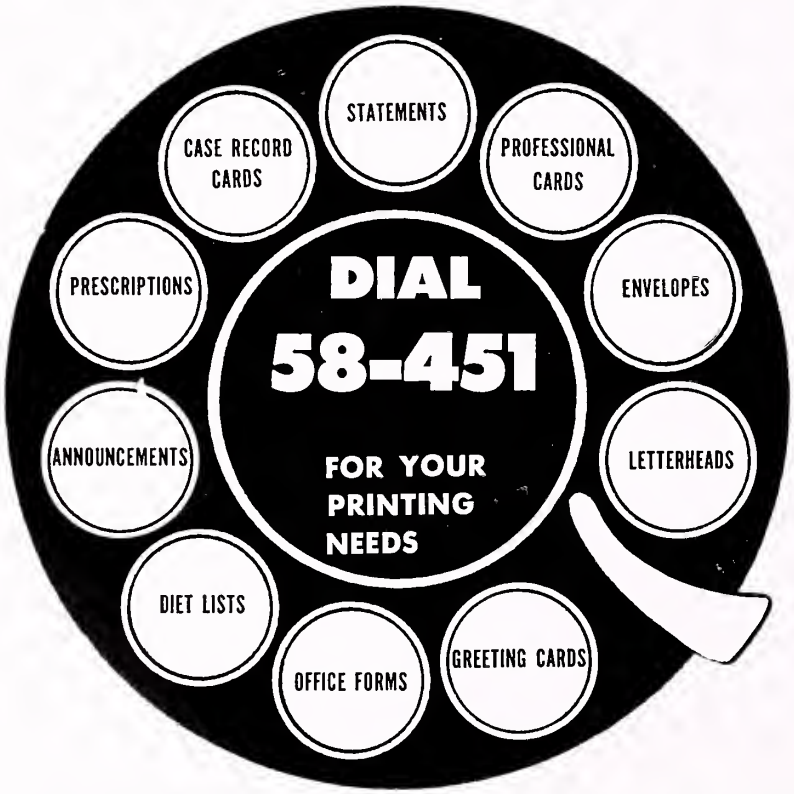
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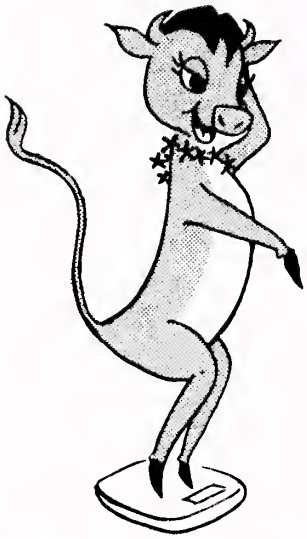


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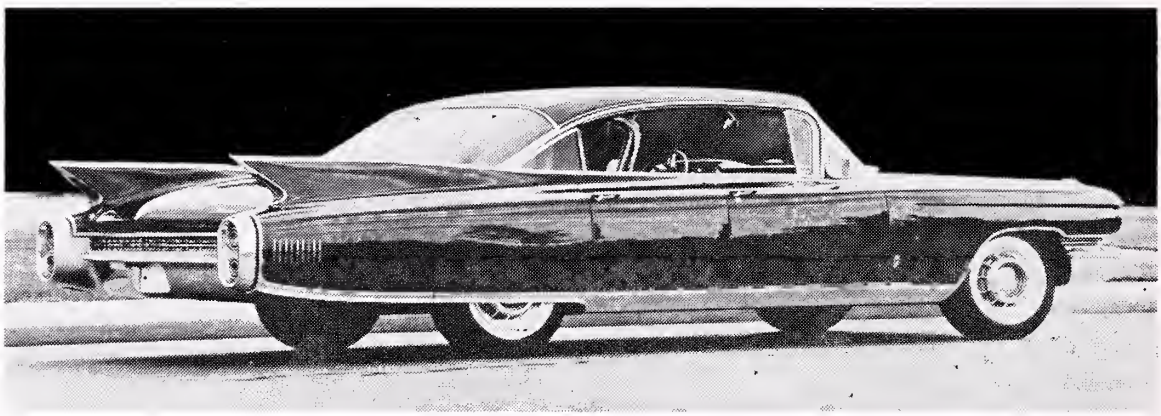


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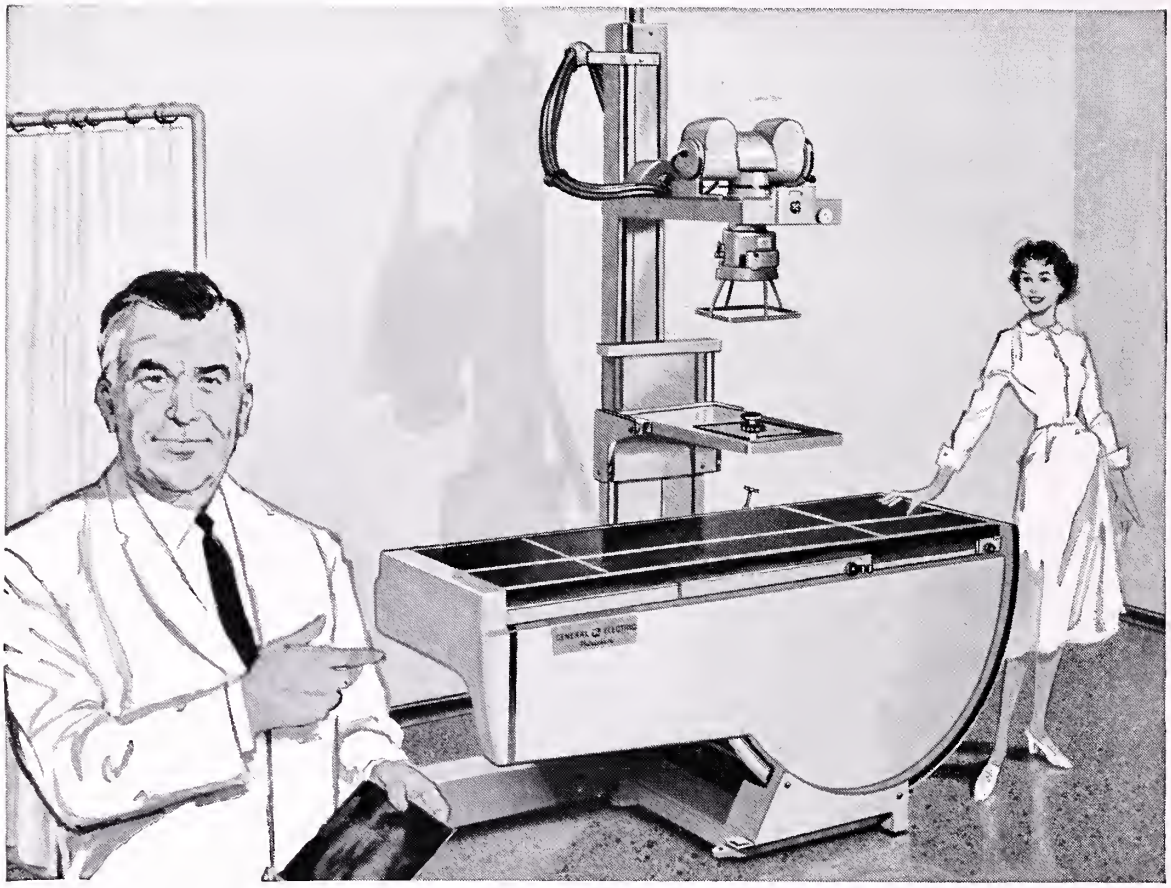
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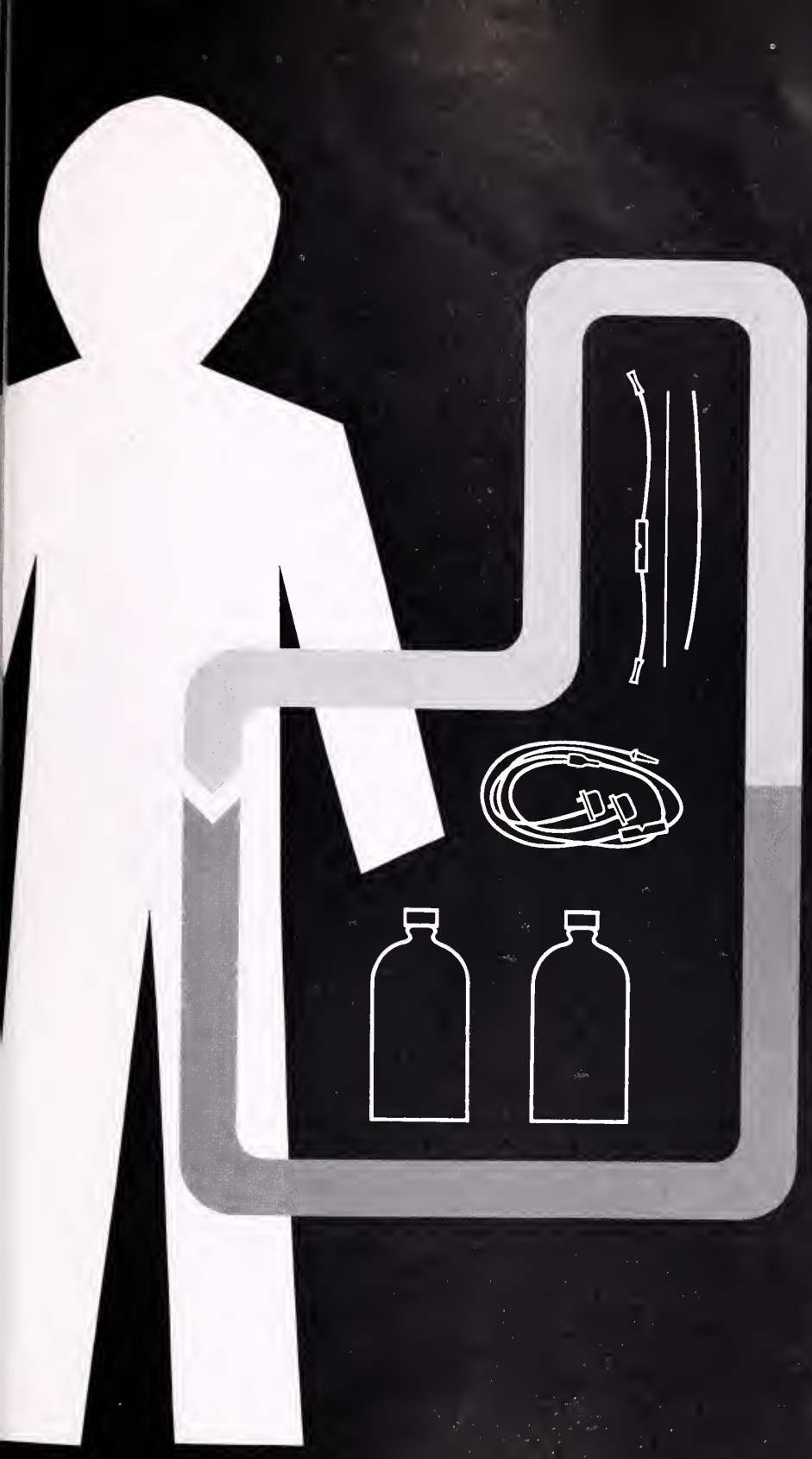
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A puzzling diagnostic problem in three brothers is unravelled most painstakingly.

Periodic Paralysis Associated with Hyperthyroidism in Three Brothers*

DONALD W. BROWN, M.D., Honolulu

SINCE ITS original description by Musgrave in 1727,[1] nearly 600 cases of periodic paralysis have appeared in the literature.[2] It is an uncommon disease characterized by the episodic, fairly sudden onset of mild to severe, even fatal, flaccid paralysis. Weakness begins in the extremities, particularly the legs, and spreads centrally to involve the trunk, and rarely, the muscles of the head and neck. Extensors are more profoundly involved than the flexors. The disease usually begins in the latter part of the first decade, and symptoms spontaneously disappear in middle life. Males are affected more commonly than females in a ratio of about three to one. Attacks commonly occur while the patient is at rest, often during the evening or upon awakening. Sudden inability to rise from a sitting position is frequently the first symptom. Very frequently there is a history of the ingestion of a high-carbohydrate meal a few hours preceding an attack. The paralysis lasts four to twelve hours as a rule, but very brief attacks occur and others lasting as long as 72 hours are not uncommon.[1]



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Hypopotassemia Usually Occurs

In 1934, Biemond and Daniels[5] noted a reduced serum potassium in a patient during an attack of periodic paralysis. They attached no particular significance to this finding but others soon found that lowered serum potassium values are usually obtained while paralysis is present.[6] The degree of lowering varies markedly from case to case and attack to attack. Values as low as 1.2 mEq l are on record, while at the same time many cases have

* From the Department of Internal Medicine, The Medical Group, Honolulu, Hawaii.

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[5] Biemond, A., and Daniels, A.: Familial periodic paralysis and its transition into spinal muscular atrophy, Brain 57:91-108 (June) 1934.

[6] Talbott.[4] Aitken.[7] Gammon.[8] Grob.[9] Danowski.[10] Gammon.[11]

shown no significant change in serum potassium at all. Some of these latter cases, however, may represent a separate disease entity.[12] Because of this marked variation and inconstancy of values, it is felt by nearly all authorities that the serum potassium is not the sole cause of the paralysis, but that it reflects some more basic derangement which is more important in producing the symptoms.[13]

Sodium Retention Too

Evidence that more than potassium is involved was recently produced by Conn *et al.*[16] when they reported finding fairly marked sodium retention preceding the attacks.[17] This is followed by sodium diuresis which develops with the earliest signs of recovery, correlating more closely with this phase than do changes in serum potassium. They believe the sodium retention is due at least in part to a concomitant rise in the output of aldosterone, which they were able to demonstrate by studying urinary levels of this hormone. In light of this observation, they administered 2-methyl-9-fluorohydrocortisone, a potent mineralocorticoid, to patients with periodic paralysis and found retention of potassium, probably intracellularly, as contrasted to the usual diuresis of potassium produced in normal man. A similar seemingly paradoxical response of potassium was recently described by Grob *et al.*[18] They found that insulin, which causes loss of intracellular potassium from peripheral muscle in normal man, causes uptake of potassium by muscle cells in patients with periodic paralysis. Further study of these electrolyte and aldosterone changes may lead the way to the discovery of the underlying defect in this disease.

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Hyperthyroidism May Cause Attacks

Approximately eighty per cent of the reported cases of periodic paralysis up to 1955 were familial. The rest were sporadic.[3] A large percentage of these sporadic cases were associated with hyperthyroidism. Hector McKenzie, referred to by Mora,[20] may have described this relationship in 1890 when he mentioned a "giving way of the legs" occurring in Graves' disease, but Rosenfeld[21] is given credit for reporting the first case of periodic paralysis associated with hyperthyroidism in 1902. Since then, a large number of reports have accumulated.[22] Okinaka *et al.*[4] found 100 cases reported in the literature up to 1957 and added 119 more discovered by reviewing the histories of 6,333 patients with hyperthyroidism in Japan. Their incidence of periodic paralysis in males with hyperthyroidism was 8.2 per cent; 0.4 per cent of thyrotoxic females were involved; and the overall incidence was 1.9 per cent. They postulate that either the combination of diseases may occur more commonly in Japan, or cases are considerably more common than previously suspected. Lindner's report[3] would suggest that the latter may be true, for he found four cases of periodic paralysis in 63 patients with thyrotoxicosis treated at the Brooklyn Veterans Administration Hospital from 1950 to 1954. The age of onset of the paralysis is later when associated with hyperthyroidism, usually occurring in the third to fourth decade. All authors have reported cure of the periodic paralysis with correction of the thyroid condition.

The most likely explanation for the association of the two diseases is felt by many to be that as hyperthyroidism develops it precipitates an underlying tendency to periodic paralysis that would otherwise remain subclinical. It has been suggested that this aggravation is mediated somehow through a change in carbohydrate metabolism produced by

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the thyrotoxicosis, but there is as yet no direct evidence to prove this contention.[31]

Case Reports

The following records deal with three Japanese brothers, each of whom had a toxic thyroid removed resulting in cure of periodic paralysis. I have been unable to find a more striking instance of familial occurrence of the two diseases in combination recorded or referred to in the English literature.

CASE 1: The patient, a thirty-seven-year-old Japanese man, was essentially well until October 26, 1958. In the evening after lying down for approximately two hours on his living room floor and watching television, he tried to get up but found that his legs were too weak to support him. This weakness did not seem to involve the upper extremities and was associated with no other symptoms or pain. He crawled into his bedroom and went to sleep. On awakening the next morning, he felt perfectly well and was as strong as ever. Two days later, during the evening after a fairly high-carbohydrate dinner, he again noticed the same symptoms. The weakness was nearly gone the next morning, and by noon had disappeared. At that time he was admitted to The Queen's Hospital in Honolulu for study.

The patient's past history revealed that in 1941 at 6:30 one morning he got up feeling perfectly well. He started downstairs, but suddenly his legs gave way and he fell to the bottom. He had to pull himself up by his hands and his legs felt extremely weak and wobbly. Later that morning, while at work, his legs "just gave way" again and he fell backwards. He remained weak for the rest of the day, but the following morning he was completely well. In 1946, while in the Army, the patient did twenty push-ups one morning. The next day he had to be pulled out of bed and found that he could do no push-ups at all. Extensive work-up in an Army hospital revealed no abnormalities, except that he was told there was something wrong with his heart. In 1951, during the afternoon, the patient noticed that he suddenly could not open his jaw. He went to a physician and was hospitalized for one day. Again, no abnormalities were elicited. In February, 1958, at 7:00 A.M., just after starting to work, the patient tripped and fell backwards striking his shoulders and twisting his head backwards. Following this he was bothered by pains in his neck. He saw several physicians during the next few months but no abnormalities were detected and he was treated with various forms of physiotherapy with some relief. The past history is not otherwise remarkable, except that he had a tonsillectomy in 1951. He works as a welder.

Family history revealed that one aunt had a toxic thyroid treated surgically. The patient has six brothers, ages 35, 38, 40, 42, 44, and 46. The brothers aged 35 and 46 have had almost identical symptoms to those of the patient (see cases 2 and 3). No other relatives are known to have been similarly afflicted. The patient is married and has two normal children. System review was not remarkable. There were no symptoms suggestive of thyrotoxicosis. In particular, he denied weight loss, irritability, tremor, hair change, or increase in appetite. The patient is right handed.

Physical examination on admission to the hospital revealed height, 5 feet 4½ inches; weight, 164 pounds; blood pressure, 118/76; pulse, 64; and temperature, 98.6°. He was strong and well in appearance. There was no exophthalmos. The thyroid was palpable but seemed normal in size, smooth, and regular. The heart was not enlarged, rhythm was regular, and tones were normal. There was a high-pitched blowing systolic murmur of Grade II intensity at the apex transmitted to the axilla, compatible with early mitral insufficiency. Complete neurological examination and search for signs of thyrotoxicosis were negative.

Laboratory findings were as follows: red blood cell count 4,580,000, hemoglobin 13.5 grams, packed-cell volume 42%, white blood cell count 8,100, with 58% polymorphonuclears, 38% lymphocytes, 2% eosinophils, 2% monocytes, and 1% stabs. Urine was yellow, clear, pH 5.0, specific gravity 1.020, albumin and sugar negative, 0-1 white blood cells and a few squamous epithelial cells. Routine VDRL was nonreactive. A Diagnex blue test revealed free gastric acid. Lumbar puncture revealed initial pressure of 155 centimeters water and final pressure of 120 centimeters. There were two white blood cells and five fresh red blood cells per mm^3. Pandy was negative. Total protein was 28 milligrams per cent, chlorides were 710 milligrams per cent. Hinton was negative. Manometrics were not remarkable. Chest x-ray was within normal limits. Electrocardiogram obtained three days after admission while the patient was not having symptoms was within normal limits. On November 5, 1958, a cervico-lumbar myelogram failed to demonstrate abnormalities of any sort.

During this first hospitalization on two occasions the patient again developed the same symptoms of leg weakness. Examination during an attack revealed no neurologic abnormalities, except for moderate, diffuse muscular weakness of the legs and slight weakness of grip on the right as compared to the left. Urinary retention developed during one attack and was relieved by catheterization. Ankle clonus was present bilaterally during the recovery phase of both attacks. On October 28, while symptom free, serum potassium was found to be 4.5 mEq/l. On November 1, while he was having moderate symptoms, serum potassium was 4.1 mEq/l. On November 7, the patient was discharged on potassium chloride, one gram three times a day. After discharge while on oral potassium, the patient continued to have mild bouts of leg weakness nearly every evening. It was noted that even between attacks there was a slight decrease in his grip on the right as compared to the left. On November 17, 1958, a basal metabolism rate was plus 34.

At this time he was started on propylthiouracil, 100 milligrams every eight hours. The following day after eating a lot of rice the patient had the most severe bout of weakness he had ever had and had to be carried into the hospital. Examination at this time revealed that the upper extremities were weak. There was marked weakness of the lower extremities of a diffuse variety, most marked in the quadriceps. Definite ptosis was present. He was given 0.5 milligrams of Prostigmine intramuscularly, with no improvement. Serum potassium was 3.1 mEq/l and blood glucose was 130 milligrams per cent. The following morning the patient felt completely well and was again discharged.

Two days later he was again admitted to the hospital with severe leg weakness. Serum potassium on this admission was 4.3 mEq/l. He was given three grams of potassium chloride intravenously over a three-hour period. Within forty-five minutes after the start of the infusion, he was completely asymptomatic. Basal metabolic rate the following day, November 21, was again plus 34.

[31] Talbott,[1] Hildebrand,[26] Millikan.[29]

This time the patient was discharged on a low-carbohydrate high-potassium diet and given oral potassium chloride as previously. Propylthiouracil, 300 milligrams per day was continued. On his diet, the patient had no severe bouts of weakness, but in the evening on two occasions after eating more than the usual amounts of bread he noted mild leg weakness. On December 10, 1958, a white blood cell count was 5,200 with 38 per cent polymorphonuclears. Propylthiouracil was discontinued and he was started on Lugol's solution, 10 drops every eight hours.

On December 27, 1958, subtotal thyroidectomy was performed. The thyroid was found to be moderately enlarged. Blood loss was considerable since the gland seemed to bleed more easily than is usual for cases properly prepared for surgery. Following surgery the patient did very well. He was discharged on December 31 without medication or special diet. One month after surgery basal metabolic rate was minus 6. He is again working full time as a welder and has had no more symptoms of weakness. The persistent slight weakness of the right hand has now disappeared so that the grip on the right is stronger than on the left.

Pathological description of the thyroid shows that the excised portion weighed 20 grams. One lobe measured 5.5 by 3 by 2 centimeters, and the other measured 5.5 by 3 by 1.5 centimeters. On section the parenchyma was uniform in appearance and consistency. Multiple sections revealed a macro- and micro-follicular thyroid with tendency to lobulation. The cells lining the follicles were cuboidal. Occasional papillary formation was noted. Colloid was moderate in amount. There was a prominence of interstitial lymphocyte accumulation with primary and secondary nodular formations. The picture was that seen in a diffuse parenchymatous hyperplasia with postulated thyroglobulin leakage and the establishment of an autoimmune process.[32] Pathological Diagnosis: Chronic lymphoid thyroiditis ("Hashimoto" thyroiditis) with focal glandular hyperplasia.[33] (Fig. 1.)

Comment

Both diagnoses in this case are open to some question. Because of the intermittent presence of ankle clonus, development of urinary retention on one occasion, and history of neck injury in the recent past with persistent neck pain, a cervicolumbar myelogram was performed before efforts to study either the radioactive iodine uptake or protein-bound iodine were made. In addition, no clinical symptoms or signs of thyrotoxicosis were present.

The diagnosis of hyperthyroidism in this case then rests solely on the following facts: (1) The two basal metabolic rates recorded were done under very satisfactory conditions and in two different laboratories one week apart. Both were plus 34. (2) The patient's episodes of weakness disappeared after thyroidectomy. (3) He had a family history of goiter. (4) The pathological findings are suggestive of hyperthyroidism in association with chronic thyroiditis, but not diagnostic of it.

The case for periodic paralysis is more certain. An intensive effort was made to exclude all other neurologic diseases. The findings mentioned previously which led to performing a myelogram are still not explained, but I feel they are either artifactual, or in some way related to the periodic paralysis. The history of episodes of severe weakness precipitated by ingestion of high-carbohydrate meals, over a seventeen-year period, is very suggestive of periodic paralysis. The suggestion is further supported by the relief of symptoms by intravenous potassium, prevention of attacks by a low-carbohydrate diet with added oral potassium, and the finding of a serum potassium of 3.1 mEq/l on one occasion during an attack. The diagnosis of periodic paralysis seems warranted.

Second Case Report

CASE 2: The younger brother of Case 1, age 35, was well until March, 1949. One evening he noted the sudden onset of leg weakness. The next morning while getting out of bed he fell down. There were no further symptoms. In June and October of that year he had similar episodes. On one occasion he fell down while walking along a street, due to sudden weakness of his legs. At this time the patient was in the Army and serving in Japan. He was hospitalized for two weeks and no abnormalities were found. He was discharged back to duty. The following year in August his legs again became weak very suddenly and he was unable to walk. This disability lasted for approximately two days and then subsided spontaneously.

He was again hospitalized. This time it was noted that he had an enlarged thyroid, and he was treated with "pills and iodine." From that time on the patient had no further leg symptoms at all. His appetite increased, he slept well, and did not feel nervous. He had no trouble breathing or swallowing, nor did he feel any pressure in his throat. He did complain of slight hoarseness. His weight was 116 pounds as contrasted to his usual weight of 130 pounds. No other symptoms of toxic thyroid were present. Two basal metabolic rates were plus 16 and 20. Electrocardiogram was within normal limits except for sinus tachycardia. The remainder of the physical examination and laboratory work was within normal limits.

Psychiatric interview at this time was performed and it was the psychiatrist's opinion that most of the patient's difficulty was on the basis of hyperthyroidism. He was transferred from the station hospital to the Tokyo Army Hospital on August 15, 1950. Here, blood count, urine, and serology were normal. A basal metabolic rate done on September 1 was minus 6. On September 11 it was plus 24. An electrocardiogram again showed sinus tachycardia.

The patient was placed on propylthiouracil, 400 mgm daily. This was later reduced to 300 mgm daily. He also received Lugol's solution in a dosage of 14 drops a day. During his stay in the Tokyo Army Hospital he gained approximately 16 pounds, going from 104 to 120. The patient was then transferred to Tripler Army Hospital in Honolulu. Past history and system review were otherwise not remarkable. (Family history is as stated in Case 1.)

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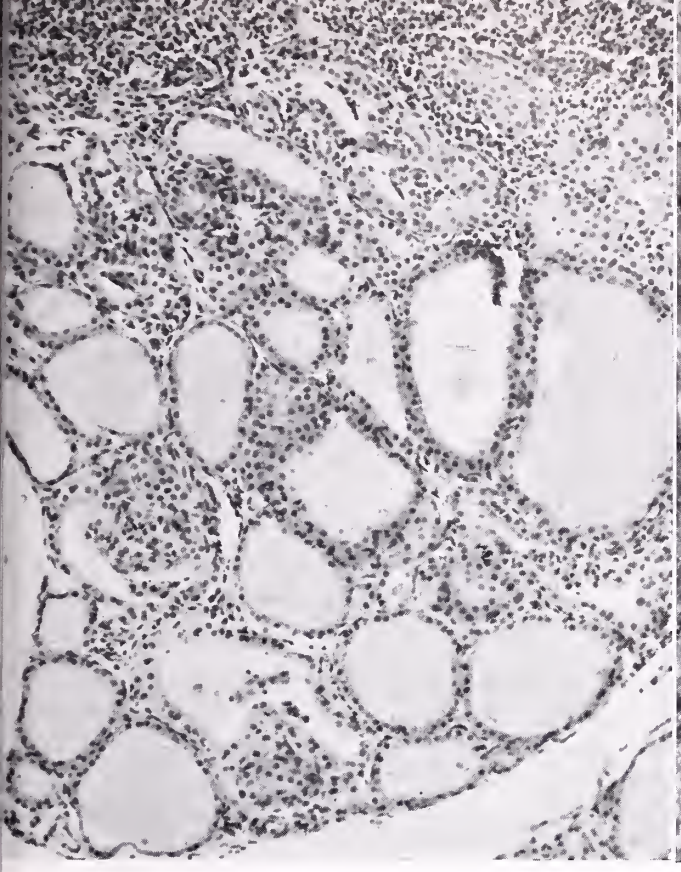


FIGURE 1 (CASE 1). *Intrafollicular colloid is spottily distributed. No scalloping of colloid is seen. The follicular lining cells are cuboidal. Papillary infoldings are not marked. Interfollicular epithelial cells are not prominent, but extra-follicular lymphocytes and histiocytes are very prominent. Some intrafollicular histiocytes are seen. The picture is that of a lymphoid thyroiditis.*

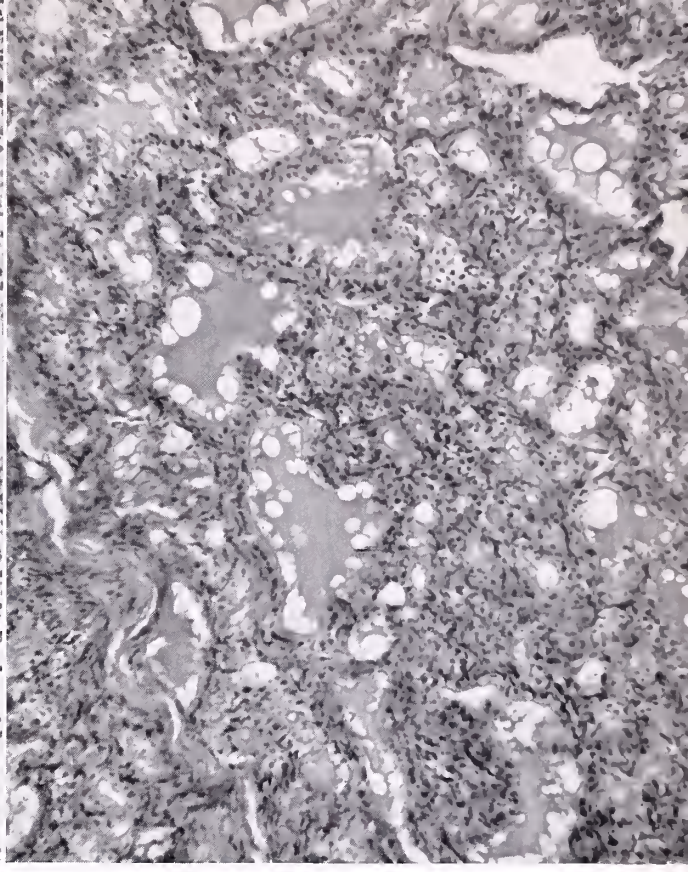


FIGURE 2 (CASE 2). *There is colloid in follicles with scalloping of edges. The follicular lining cells are cuboidal and form short papillary infoldings. The extra-follicular proliferation of cuboidal epithelial cells occurs in sheets. The picture is one of parenchymatous hyperplasia of the thyroid showing evidence of antithyroid medication.*

The patient arrived at Tripler Army Hospital on December 6, 1950. Physical examination revealed slight exophthalmos. Extraocular movements were normal. The thyroid was enlarged to palpation, but smooth, and no nodules were felt. Blood pressure was 118/74, the heart was not enlarged. There was a regular rhythm at a rate of 108. The remainder of the physical examination was entirely negative.

Laboratory work was as follows: Urinalysis and serology were normal. Several complete blood counts were obtained from December to April and showed a slight relative lymphocytosis. Cholesterols were also frequently obtained and varied from 210 to 330 milligrams per cent. Glucose tolerance test was within normal limits. Prothrombin time was 100 per cent. Basal metabolic rates were plus 30 on December 11, 1950, plus 63 on December 18, plus 40 on December 20, plus 41 on December 28, plus 40 on January 3, 1951, plus 24 on January 8, plus 20 on January 15, plus 8 on January 22, plus 3 on January 29, minus 8 on February 19, and minus 8 on April 17. Chest x-ray was normal.

On admission it was thought that this patient had a typical picture of thyrotoxicosis. He was placed on phenobarbital and a high caloric diet. On December 28 he was started on propylthiouracil, 400 mgm per day. On January 11, 1951, this was increased to 600 mgm per day. On January 19 Lugol's solution, 19 drops t.i.d., was added. On February 5 a subtotal thyroidectomy was performed. Considerably more bleeding was encountered than is usual for an operation of this type, but recovery was uncomplicated. On February 23 the patient was sent on convalescent leave, returning on April 15. At this time he felt well, was not nervous, and the wound was well healed. He weighed 144 pounds. Repeat basal metabolic rate on April 19 was minus 8. He was discharged to duty on April 20, 1951.

Microscopic sections of the thyroid (Fig. 2) showed the standard pre-surgically prepared hyperplastic thyroid. The follicles were lined by tall columnar cells with some papillary infolding. Follicle lumens were of moderate size and contained colloid. Some cell proliferation was seen. Practically no lymphoid areas were present. Pathological Diagnosis: Diffuse parenchymatous hyperplasia, thyroid, treated.

Following discharge the patient has remained completely well up to the present time, and has had no further symptoms of muscular weakness.

Comment on Case 2

In this case there can be little doubt regarding the diagnosis of mild thyrotoxicosis. The diagnosis of periodic paralysis was not established in the patient at the time of his being under actual medical observation, and thus, very meager details regarding his attacks of leg weakness are available. No episodes are recorded in his chart as having occurred while in Tripler Army Hospital. This is difficult to explain, since that is the time at which

he was apparently most toxic. No potassium studies were made. His history, nevertheless, is one of periodic paralysis.

The question is, was this periodic paralysis of the type under discussion in this article, was it on a psychoneurotic basis, or simply weakness due to the toxic thyroid? He was studied carefully psychiatrically and it was the impression of several psychiatrists that his symptoms were on the basis of organic disease. His history of the attacks of periodic leg weakness over a period of eighteen months, relieved finally by the correction of hyperthyroidism, is so typical of the many cases in the literature and so unlike any other condition that I feel the diagnosis of periodic paralysis associated with hyperthyroidism in this case can be accepted.

Third Case Report

CASE 3: The eldest brother of Cases 1 and 2, a forty-six-year-old Japanese man, in 1940 suddenly began to have periodic bouts of leg weakness, usually coming on in the evening and often precipitated by prolonged sitting in a chair, after which he would suddenly find he could not stand up. The patient was examined repeatedly by his private physician and no cause was detected. The symptoms of periodic leg weakness continued to recur every few days for several months. At that time his thyroid gland was found to be enlarged and basal metabolic tests revealed overactivity of the gland. He went to Japan where uneventful subtotal thyroidectomy was performed after he had been given "pills and iodine." Following his operation in 1940, the patient returned to Hawaii where he has remained in excellent health since, and has never had the slightest indication of leg weakness.

Comment on Case 3

Unfortunately, the author has not been able to interview this patient personally, and the above information was gathered from relatives. The diagnosis of periodic paralysis associated with hyperthyroidism must rest only upon what is recorded here and the unlikelihood that any other association of illnesses or illness could explain this set of circumstances.

Discussion

As stated previously, Okinaka found an incidence of periodic paralysis of 8.2 per cent in Japanese males with thyrotoxicosis. That any three randomly selected cases of hyperthyroidism would have the association of the two diseases would then be most unlikely—less than one in a thousand. Thus, the chances are great that in these three brothers the periodic paralysis is familial, despite the fact that periodic paralysis, when it occurs in association with hyperthyroidism, has previously been felt to be sporadic.

Other instances of the combination of diseases occurring in more than one member of a family are on record. Shinosaki[23] states that a female relative of one of his patients had the two diseases. Tsuji, as reported by Seed,[14] states that the mother of one of his patients died of a combination of periodic paralysis and exophthalmic goiter. Hildebrand[26] also reports a case of thyrotoxicosis and periodic paralysis who had a brother with a similar attack of weakness, but no mention is made of a toxic thyroid condition. Okinaka's report states, "a family history of periodic paralysis was noted in only one of the 119 subjects" with the combination of diseases. No further details are given.

Thus, periodic paralysis occurs in the family in four of the 220 cases available in literature. Information is not available to estimate at all accurately how many patients with toxic goiter would be included in the family history of these 220 recorded patients. Perhaps the best guess would be that four cases of periodic paralysis occurred in 66 (thirty per cent of 220[34]) relatives with thyrotoxicosis, for an incidence of six per cent. This is a higher figure than the overall incidence of 1.9 per cent found by Okinaka for periodic paralysis in patients with thyrotoxicosis. The differences between these figures cannot be considered statistically significant, but it can be suggested that the periodic paralysis associated with hyperthyroidism is, at least in part, familial.

Summary

Clinical manifestations of periodic paralysis and some recent discoveries of interest with regard to sodium and potassium metabolism in this disease are reviewed. The relationship of periodic paralysis to thyrotoxicosis is also considered and the literature on this subject is summarized.

Three Japanese brothers with the association of diseases are presented. It is suggested that in their cases, and possibly in others, periodic paralysis associated with hyperthyroidism is familial.

Summario in Interlingua

Le occurrentia de paralyse periodic in tres fratres esseva associate con varie grados de hyperthyroidismo. Es facite le suggestion que le association habeva un base familial. Le pertinente litteratura es revistate.

Acknowledgment

I wish to thank Dr. W. Harold Civin of the Pathology Department at The Queen's Hospital, Honolulu, for preparation of the pathological material for presentation.

[34] Rundle, F., and Sydney, M.: A study of the pathogenesis of thyrotoxicosis, The Lancet 2:149-152 (Aug. 9) 1941. Moolten.[35] Werner.[36]

[35] Moolten, R., and Bruger, M.: Exophthalmic goitre of the juvenile type—A survey of the literature on the familial aspects of this disease and a report of two additional cases, Arch. Surg. 45:623-632 (Oct.) 1942.

[36] Werner, Sidney C.: The Thyroid: A Fundamental and Clinical Text, Paul B. Hoeber, Inc., N. Y., 1955.

Presidential Address

TORU NISHIGAYA, M.D., Honolulu

MY TENURE of office ends tonight. The year seems to have slipped by with much too little tangible evidence of accomplishment. Many problems have come before us, great effort in time and energy has been expended to do what little that has been done.



Bauer

DR. NISHIGAYA

No administration can lay claim to its accomplishments without proper acknowledgments to people surrounding them. My task would have been impossiblly complex without their help. As always, our fellow colleagues contributed immeasurably and willingly, to the betterment of the Association.

To the governing board of this Association, the Council, I extend heartiest thanks for their timely and sage deliberations in shaping the policies, and in keeping me and the rest of the members in line.

Our Legislative Committee, under the inspiring chairmanship of Dr. Leabert R. Fernandez, spent many hours to enhance the profession's position in legislative affairs. Their thinking and accomplishments have placed the medical profession in an enviable position in regard to future legislative activities in the State.

The Health Education Committee, under the able leadership of Dr. Katherine J. Edgar, has contributed greatly to betterment of public relations and education of the public. Most of you are not aware of the hours of hard work and planning put in by this Committee, to present educational material for public consumption.

The Chronic Illness Committee, under Dr. L. C. Beck, has been conscientiously trying to solve the problem of the aging—a subject which in my mind is or will soon become the most pressing problem in the nation. Their task has been most difficult but their sound deliberations are gradually moulding the problem into proper perspectives so that results will be soon forthcoming.

The Advisory Committee to the Bureau of Maternal and Child Health, under Dr. C. A. Wyatt, has also contributed materially to our efforts. Their diligent efforts are constant reminders of the great stride and leadership that we in Hawaii have taken toward maternal and infant care.

The Emergency Medical Service Committee, under Dr. I. A. Kawasaki, has spent countless hours doing a thankless job of preparing the community for disaster. They have had to continue under adverse situations of apathy and complacency on the part of the profession as a whole, and the general public, as well as lack of materials to work with. In spite of these obstacles, the Committee has made sound plans and is prepared for any disaster, come what may. Our thanks to them.

Much credit goes to our executive secretary, Miss Lee McCaslin, whose untiring, sincere, conscientious efforts on our behalf should not go unrecognized. With proper guidance, her true devotion to the Association has been uncovered and truly, without her help, my duties would have been tremendous.

Read at the 104th annual meeting of the Hawaii Medical Association, May 13, 1960.

There are other members, and committees too many to enumerate, who served in the interest of the Association. To them, many thanks.

The medical profession is always beset with numerous problems and challenges. For over a century, the profession in Hawaii has accepted and met these. Our isolated, polyglot population lends itself to many peculiar situations bringing weighty problems.

By the same token, it offers us challenges and opportunities to meet them. The medical profession in Hawaii is in an enviable position to enhance itself in the eyes of the world. The very things creating those problems lend themselves to study and research.

Hawaii should be the focal point in the study of a multitude of diseases; a center of research; and a great center to contribute to, and advocate the enhancement of, East-West medicine and culture.

True, study has already been instituted and some results seen, but much more can be accomplished with the right kind of thinking and proper leadership from the profession. We can and should anticipate greater results in the future.

The study of malignant growths with their peculiar predilections has already been instituted. Our curiosity has already been aroused by the great evidence of cancer of the stomach in the Japanese, with a significant decline in cancer of the breast in the Japanese female. The problem is intriguing and our captive population lends itself to its study and possible solution. We must continue to work at it.

Relatively high death rates from heart diseases have been found among Hawaiians, Chinese and Caucasians while relatively low rates have been noted among the Japanese and Filipinos. These people all live in the same environment—a condition which exists only in Hawaii.

Recent studies here have included blood cholesterol and diets in the Japanese in an effort to glean something about the process of atherosclerosis. These research projects are "made to order" here in Hawaii and more concerted thinking and research are mandatory to bring better results.

The much publicized Filipino "mystery deaths," peculiar to these people, lends itself to study. Why should deaths occur in them under such peculiar circumstances? Here is a problem that seems intriguing with possibilities of solution.

Diabetes, leprosy, tuberculosis and other chronic illnesses may similarly be attacked. Much has already been done in leprosy and tuberculosis, but I am certain improvement can be had if more diversified and intense efforts are expanded.

The ravages of other communicable diseases have been lessened or eliminated by the program of our Health Department. We are proud of the health program of the Department of Health. We could be equally proud of the medical profession as a whole. It is only for the profession to be alert and cognizant of these conditions—be aware of its peculiarities and possibilities, and with some effort and a little luck, someone may, some day, be gratefully rewarded.

We have the challenge—we have an ideal "experimental station" and research center. Do we accept the challenge? I do so on behalf of the profession, confident that we have the skills, the knowledge and inquisitiveness to meet the situation. Thank you and Aloha!

764 Kapahulu Ave.

THE GOOD OLD DAYS

"I do not want to live under a philanthropy. I do not want to be taken care of by the government either directly or indirectly, or by any instrument through which the government is acting. I want only to have right and justice prevail so far as I am concerned. Give me right and justice and I will take care of myself. . . . I will not live under trustees if I can help it. . . . I do not care how wise, how patriotic the trustees may be. . . . I have never heard of any group of men in whose hands I am willing to lodge the liberties of America in trust."

WOODROW WILSON, in *The New Freedom*

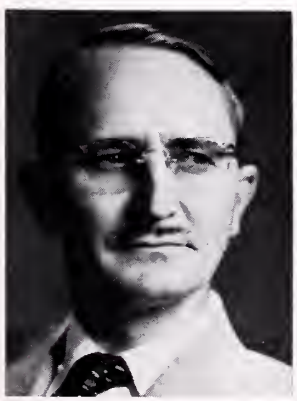
The visually handicapped need much more than just sympathy—

and physicians must know what is available for their help

Total Eye Care

O. D. PINKERTON, M.D., Honolulu

THE PURPOSE of this paper is to review the various ancillary services for the visually handicapped, and to urge ophthalmologists to continue their observation, care, and recommendations *after* they have ceased whatever medical or surgical care deemed necessary. Busy medical men frequently fail to report visually handicapped patients, and thus involuntarily deprive them of whatever services are available in their respective communities. Too frequently these unfortunate people learn of such services accidentally from neighbors, or friends, or similarly handicapped individuals. They naturally wonder why their eye physician or family physician failed to follow through with appropriate recommendations for rehabilitation.



Bauer

DR. PINKERTON

Received for publication December 20, 1959.

In many instances the physician, in his attempt to cure the disease process, loses sight of the fact that the patient will require visual rehabilitation.

Talking Book Machine

This aid probably serves best as a temporary means of assistance for those cases under medical or surgical observation or treatment. As a long-term aid it should be used more often in the elderly person who would not be too easily trained in Braille, and could not be helped by visual aids because of the severity of his condition or psychological reasons of inadaptability.

Visual Aids

Aids should be tried on all visually handicapped who can at least count fingers at four feet. Common sense is the basic requirement in the decision to prescribe visual aids and what type of visual aid to prescribe.

Ordinary plus lens from the trial case is the one essential tool. Other lenses are refinements and, of course, are desirable. Telescopic spectacles should be tried, although generally speaking they are rarely successful either for distance or near. The

dispensing optician should have a trial set available for the use of several ophthalmologists. A minimum of two visits and a maximum of four visits to the ophthalmologist has been found desirable and effective in determining whether a patient will be benefited and what type of aid to prescribe. Naturally the intelligence of the patient, his age, and motivating factors will affect the outcome of this effort. Too often, after the expenditure of considerable money, the patient decides that his old hand magnifying glass works better than his expensive glasses. This is particularly true in elderly patients.

Braille Reading

This, of course, is valuable for the more intelligent individual who might use it for pleasure or business occupation, or both. One should wait until all hope of visual aid utilization has ceased and until the patient has adapted himself psychologically to the fact that he is truly blind, because the mention of "Braille" connotes blindness in the thinking of any average individual as does the mention of a guide dog.

Occupational Adaptation

Occupational adaptation is the final and most important step in the rehabilitation of the visually handicapped. Motivation is important here and is related to the age of the individual, family responsibilities, etc. The choice of occupation should naturally be geared to the intelligence and capability of the individual.

There has probably been too much said about "making the patient understand his handicap" and too frequently physicians delegate this responsibility to nonmedical or auxiliary personnel. It is the physician's duty to spend more than a casual few minutes with a blind or visually handicapped person at each office visit, and not be too busy to complete the task of informing the patient of his future and how he should try to meet his problem. Abrogation of this responsibility too often separates the physician from this tender aspect of physician-patient relationship. Blind people want our sincere consideration of their problem.

Summary

Physicians owe their blind and visually handicapped patients care, consideration, and time over and beyond their medical and surgical treatment. Rehabilitation should begin with and be guided by and ended by the physician.

Summario in Interlingua

Le quatro principal medios de rehabilitation in cecitate o quasi-cecitate es machinas a "libro parlante," adjutas visual, le methodo Braille, e le adaptation professional. Le medico, troppo frequentemente, non considera omne istos in planar le regime in casos de cecitate e age plus tosto secundo le conception pessimista que nihil pote esser facite.

Room 230, Alexander Young Bldg.

This is not for ordinary do-it-yourselfers,

but heart surgeons will find it of great interest.

A Temperature Control Unit for a Commercial Disc Oxygenator*

PAUL W. GEBAUER, M.D., SCOTT C. BRAINARD, M.D.,

CARL B. MASON, M.D., and MARY CONNOR, B.S., M.T. (A.S.C.P.) Honolulu

IN PARTICULAR situations the surgical and physiologic advantages of deep hypothermia are established. When a surgical procedure does not permit access to the heart hypothermia is limited to a lower range of 30°C. to 28°C. to avoid cardiac irregularities, particularly ventricular standstill and fibrillation, which occur quite regularly between 26°C. and 22°C. On the other hand, in open heart surgery these changes do not have to be avoided; in fact, they may be technically desirable. Furthermore, with temperatures below 18°C., complete, but reversible, cardioplegia occurs, and metabolic requirements drop to below 25 per cent of normothermic levels. Such a state may be a great help to the surgeon and the patient, especially in prolonged, difficult surgical procedures on hearts with massive flows.



Bauer

DR. GEBAUER

Consequently, there is an increasing use of hypothermia combined with extracorporeal circulation, and heat exchanger units are being added to perfusion equipment. These add another unit to the blood circuit, which is rather complex to begin with, and they require additional blood for priming.

A temperature control unit which largely overcomes these two objections, and is adaptable to the popular Kay-Cross disc oxygenator, has been constructed and used in the experimental laboratory. It was first tried in December, 1959, and to date has been used in eleven extracorporeal perfusions. Before this a somewhat similar unit was developed and used on animals and patients, by Urschel, Greenberg, and Roth.[1]

Figure 1 illustrates how the Kay-Cross oxygenator is altered to be fitted with our heat exchanger unit. Removal of the oxygen tube permits a lower position of the glass cylinder in the end plate recesses, creating an adequate space at the bottom,

* Aided by a grant from the Hawaii Heart Association.

From the Experimental Surgical Laboratory, The Queen's Hospital, Honolulu.

Received for publication April 8, 1960.

[1] Urschel, H. C., Greenberg, J. J., Roth, E. J.: Rapid extracorporeal hypothermia. Research Report N M 71 0300.01.03. Naval Medical Research Institute, Bethesda, Md., 1959.

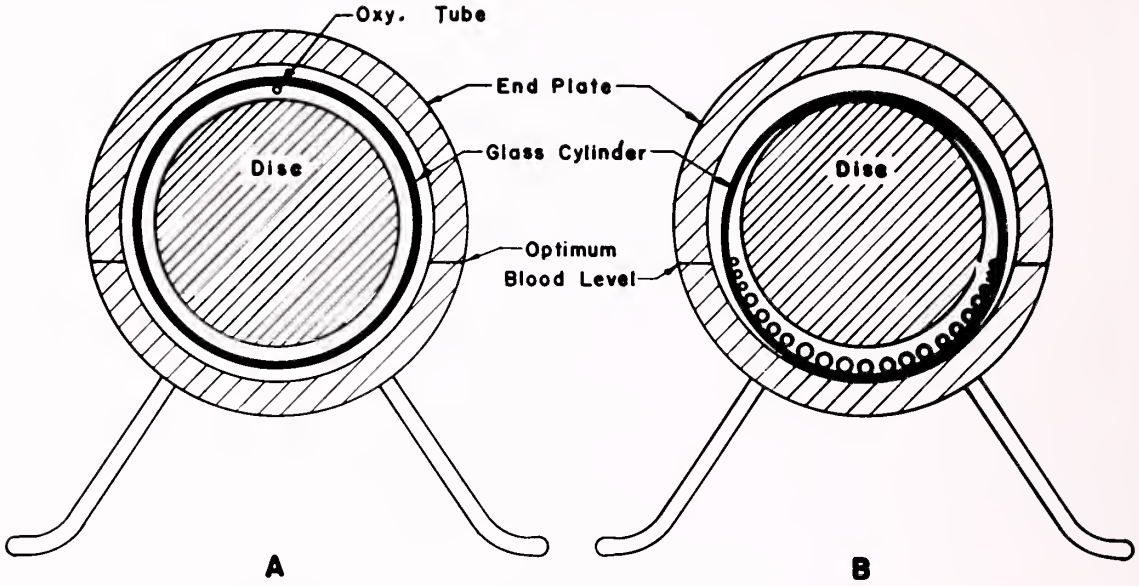


FIGURE 1, A and B. *Diagram of cross section of Kay-Cross disc oxygenator showing how removal of the oxygen feeding tube in A from beneath the top of the glass cylinder permits it to be dropped down to the bottom of the end plate recess, as in B, thereby creating a space between the cylinder and discs. In cross section this space is crescent shaped, about 11 mm. deep at bottom center, and 4 mm. at the ends which correspond with the optimum blood level. Throughout the length of the oxygenator, this space can be partially filled with heat exchanger tubing.*

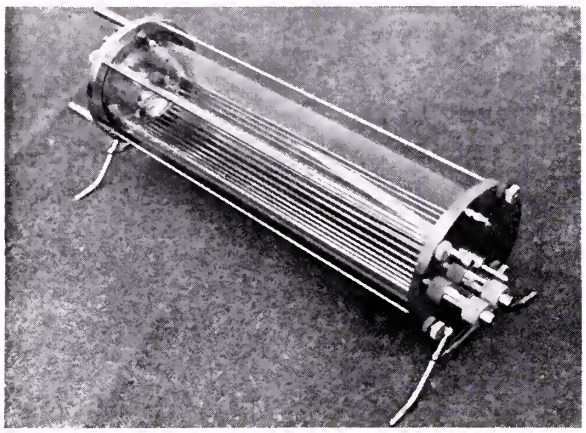


FIGURE 2. *Photograph showing how heat exchanger rests in the cylinder, and is anchored to the end plates of a 21 inch Kay-Cross oxygenator.*

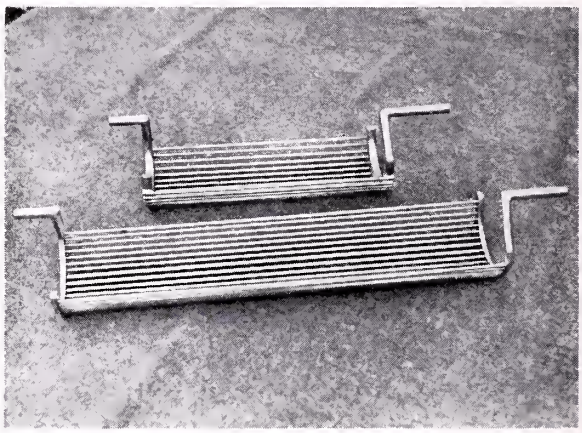


FIGURE 3. *Units for 13 inch and 21 inch oxygenators showing inflow and outflow ends which are brought through upper portions of end plates.*

between the discs and the glass cylinder, for heat exchanger tubing. Urschel *et al.*[1] gain space by using a larger glass cylinder.

Figure 2 shows how the unit rests in the oxygenator cylinder, and how the inflow and outflow ends are anchored by coming through new holes in the end plates. In this illustration the discs are not on the shaft. A separate unit must be constructed for each length oxygenator used.

Figure 3 shows the 13 inch and 21 inch heat control units. These are made of Type 304 stainless steel tubing. The former consists of 18 three-sixteenth inch tubes, three-sixteenths inch apart. The curved end conduits are stainless steel tubing one-half inch outer diameter. Joints are silver soldered. If the blood level is kept constant in relation to the discs and spacers, the lower position of the glass cylinder, or a larger glass cylinder, will naturally increase the priming volume. However, the displacement volume of the 13 inch unit is such that the priming volume is only increased by 100 cubic centimeters.

The 21-inch unit is constructed of similar end pieces, and 21 tubes of varying size. With this unit in place, the priming volume is actually reduced by 280 cubic centimeters. In trial runs, this

unit provides very rapid heat exchange, but seems slightly less efficient than the 13-inch unit, which possibly has a more favorable ratio of tubing surface to blood volume, although experimentally both units function with a rapidity that is highly satisfactory. This is illustrated in Figure 4, which is a typical temperature chart of a perfusion experiment.

With continued experience, modifications may be introduced. To date there has been no difficulty with oxygenation because of removal of the perforated oxygen tube. The gas is fed in through one of the ports at the top of the arterial end plate; the other port was enlarged to accommodate the inflow tube of the temperature control unit. No significant increase in hemolysis has been noted, although it is certain that any unit within the oxygenator must make some contribution to turbulence.

With these units, blood temperature is so easily controlled that it seems advantageous to prime early and maintain the desired temperature of the whole system, rather than to store the donor blood in a water bath until just before perfusion.

The principle used here could be applied in other situations. Units could be constructed in the venous and arterial reservoirs of a screen oxygenator, and possibly in the helix and arterial end of a bubble system. Sterile saline could be used as a heat exchange medium to lessen the hazard in case of leakage.

Efficiency can also be increased by using faster flow rates through the exchanger and maintaining lower temperatures of the coolant by automatic chemical and mechanical control. We have simply recirculated water from an ice bath with a small "Little Giant" water pump, and the efficiency of this simple, inexpensive unit seems highly satisfactory.

Summario in Interlingua

Le thermoregulator pro anesthesia hypothermic require un grande quantitate de sanguine additional e rende le circuito extracorporee additionalmente complicate. Le hic describite dispositivo, un meliorate modification de un que es jam in uso alterubi, non augmenta le numero del stationes in le circuito extracorporee e adde solmente pauco al volumine del regular oxygenator discate.

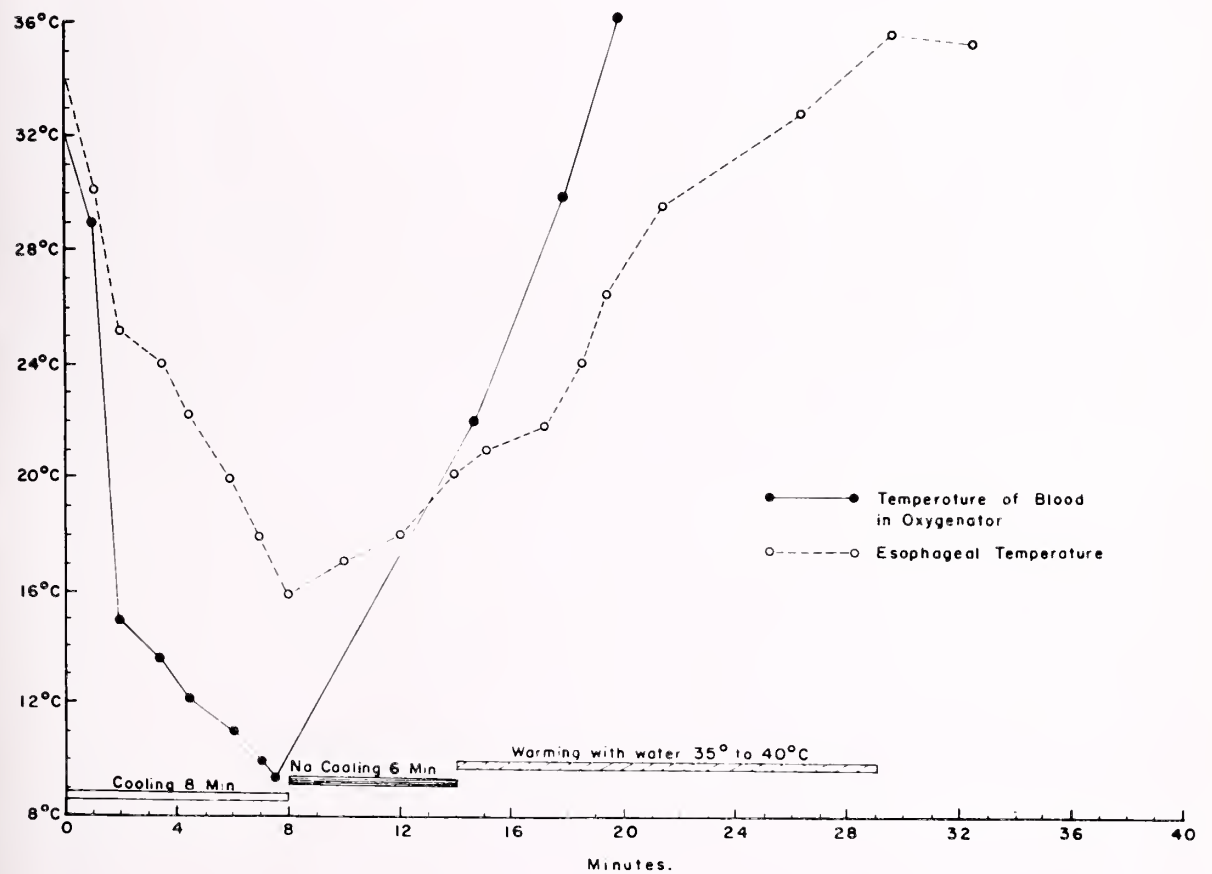


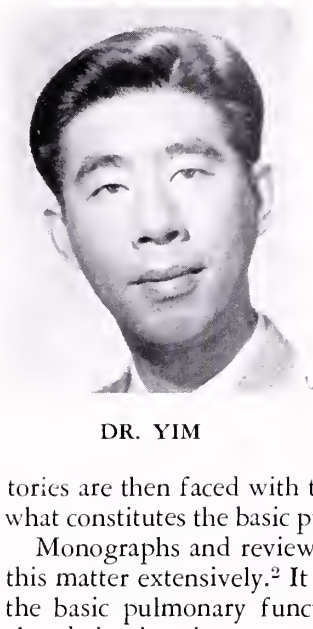
FIGURE 4. *Temperature chart of extracorporeal perfusion of 37 pound dog showing rapidity of deep hypothermia. Perfusion with 13 inch oxygenator using femoral artery as entry portal.*

Adequate pulmonary ventilation does not always result in adequate oxygenation of the blood. Better measure both!

Importance of Arterial Blood Analysis in Evaluating Pulmonary Function

BERNARD J. B. YIM, M.D., and
GILBERT A. CHING, M.D., Honolulu

MAXIMAL BREATHING capacity! Timed vital capacity! Compliance! pCO_2! Diffusion! Phrases such as these reflect the tremendous advances made in pulmonary physiology in the past decade.[1] Some of this new information has filtered down to the practicing physician and has been useful in clinical study. Much remains in the physiology or research laboratory. Because of the great impetus in this field, many physicians request pulmonary function tests for patient study. Laboratories are then faced with the problem of deciding what constitutes the basic pulmonary function tests.



DR. YIM

Monographs and review articles have gone into this matter extensively.[2] It is generally agreed that the basic pulmonary function tests must include closed-circuit spirometry and arterial blood analysis. In addition to these studies, residual volume determinations and bronchospirometry may be incorporated. More extensive tests remain a function of the research laboratory.

PATIENT	BLOOD GAS	
	O_2 CONTENT (Vol. %)	O_2 SAT. (%)
1) 63 Yrs. M Emphysema.	20.39	88.6
2) 24 F Asthma. Fibrosis. Tbc.	18.46	77.9
3) 64 M Asthma. Fibrosis. Tbc.	19.25	77.36
4) 40 F Fibrosis. Emphysema. Tbc.	17.39	68.7
5) 49 M Fibrosis. Emphysema. Tbc.	18.93	86.4
6) 54 M Tbc. Pleural Adhesions.	16.3	82
7) 34 F Tbc. Lobectomy.	17.14	82.2
8) 62 F Fibrosis. Tbc.	18.21	80.6
9) 59 F Asthma. Fibrosis. Tbc.	18.12	84.1
10) 51 M Fibrocavernous Tbc.	19.66	84.9
11) 51 M Pulmonary A-V Fistula.	21.2	93.3
12) 55 M Emphysema. Bullae.	19.77	81.9
13) 40 M Pulmonary Granulomatosis.	19.53	90.3
14) 29 F ? Hamman-Rich.	16.78	84.5
15) 20 F Kyphosis. Asthma.	17.74	82.9
16) 47 M Emphysema. Fibrosis. Tbc.	16.9	68.9
17) 43 M Fibrosis. Emphysema.	21.48	81.0
18) 31 M Asthma. Emphysema.	18.64	76.9
19) 58 M Tbc. Fibrosis. Blebs.	16.19	69.5
20) 58 M Asthma. Fibrosis.	18.82	82.3
21) 40 M Fibrosis. Tbc.	18.59	77.0

Table I. Arterial Studies of Lung

From the Cardiopulmonary Laboratory, Leahi Hospital, Honolulu, Hawaii.

This study was supported in part by a Ford Foundation Grant.
Received for publication April 12, 1960.

[1] Friedberg, C. K.: Pulmonary function tests and their clinical applications, Progress in Cardiovascular Diseases, 1:251 (Feb.) 1959.
[2] Comroe,[3] *idem*,[4] Meneely & Callaway,[5] Exhibit,[6] Stone.[7]

PCV	VENTILATORY INDICES					
				TIMED VITAL CAP. %		
%	M.B.C. (L/Min.)	% NORMAL M.B.C.	% NORMAL Vit. Cap.	1 Sec.	2 Sec.	3 Sec.
46	27.5	33	55	36	49	62
47.5	41.4	44.5	61	45	66	79
51.5	27.5	35	55	30	43	53
48	32	41	54	50	64	75
42	21.6	25	39	52	69	87
35	51.1	61	43	72	80	96
42.5	20.6	28	46	43	57	70
53	19.1	34	66	36	52	66
40.5	18.3	33	41	68	80	88
44	50.5	58	37	78	94	100
51	110	109	75	74	89	96
49	87	84	76	65	86	97
42	153	119	72	93	100	
39	80	97	70	68	96	100
42	34.4	66	57	52	93	100
55			60	33	52	63
53	41.2	34	68	41	58	65
48	34	26	50	42	59	72
48	57	75	35	89	100	
45	46	56	76	55	82	97
47	82	67	58	69	86	93

and Ventilation

ith Various Forms

Spirometry alone often falls short in detecting the degree of functional impairment. Maximal breathing capacity, vital capacity, timed vital capacity, and all other ventilatory studies are measures of ventilation alone. Helpful information is certainly gained by such studies. For example, graphic description of expiration can be obtained in an asthmatic or a patient with emphysema. An estimate of "breathing reserve" can be obtained in patients with fibrosis or bronchiectasis by measuring the maximal breathing capacity and other determinants.

The basic function of the lung in respiration, however, is to rid the body of carbon dioxide and to oxygenate red blood cells. Arterial blood analysis is a simple yet direct means of examining the lung's capacity in these respects.[8] Arterial gases and pH determinations measure modalities that spirometry alone cannot determine. Indeed, at times spirometry alone may actually be normal in the face of severe abnormalities of the blood components. Today, the major hospitals in Honolulu are equipped to do arterial blood gas analyses and pH determinations. This report illustrates the utility of this form of pulmonary function testing, which is "a primary approach to the diagnosis of pulmonary insufficiency."[1]

Methods

Twenty-one patients with varied forms of pulmonary disease were tested by closed-circuit spirometry and by analyzing arterial blood gases and pH before and after breathing 100% oxygen alone, and with the use of intermittent positive pressure with bronchodilators.

A Collins 13.5-liter respirometer was used for ventilatory measurements. An indwelling Reilly arterial needle was placed in either a brachial or a femoral artery and samples were obtained in heparinized syringes. Arterial gases were analyzed by the Van Slyke manometric method. Blood pH was measured at 37° C. on a Beckman research model pH meter. Carbon dioxide tensions were calculated, using the Singer-Hastings nomogram.[9]

Results

Table 1 lists the results of essential ventilation tests and arterial blood analysis of 21 patients.

[3] Comroe, J. H., Jr.: Interpretation of commonly used pulmonary function tests, Am. J. Med. 10:356 (Mar.) 1951.
[4] Comroe, J. H., Jr.: The Lung. Year Book Publishers, Inc., Chicago, 1955, p. 97.
[5] Meneely, G. R., and Callaway, J. J.: Respiratory Function Tests in Pulmonary Emphysema, edited by Barach, A. L., and Bickerman, H. A., Williams and Wilkins, Baltimore, 1956, p. 453.
[6] Panel Exhibit: Pulmonary function testing, A.M.A. Section on Diseases of the Chest. 1955.
[7] Stone, D. J.: Applied Pulmonary Physiology in Advances in Internal Medicine, edited by Dock, W., and Snapper, I., Year Book Publishers 7:243, 1955.
[8] Friedberg,[1] Comroe,[3] Comroe.[4]
[9] Singer, R. B., and Hastings, A. B.: An improved clinical method for the estimation of disturbances of the acid-base balance of human blood, Medicine 27:223-242 (May) 1948.

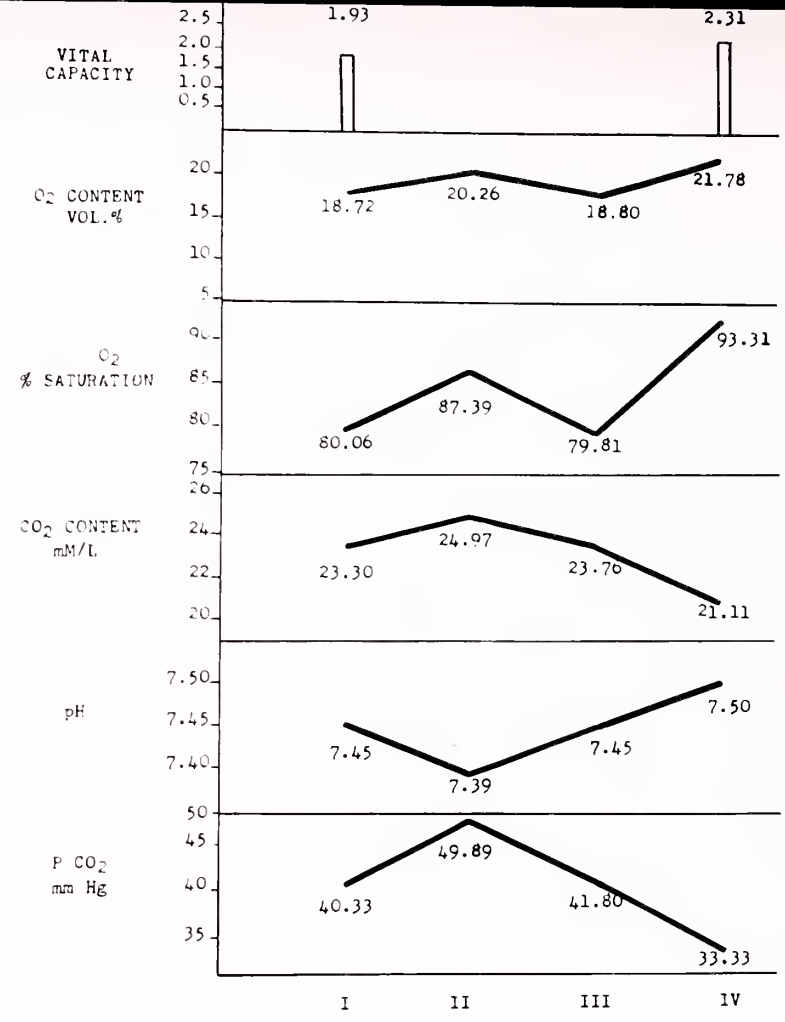


FIGURE 1. *Mean values in acute study of 9 patients.*

Period I—Control.

Period II—After administration 100% oxygen 15 minutes.

Period III—Recovery 15 minutes.

Period IV—After 100% oxygen and bronchodilators administered via intermittent positive pressure.

Good to excellent correlation was obtained in 14 patients; that is, ventilation studies paralleled arterial blood analysis. In seven cases, however, there was no correlation between ventilatory studies and arterial blood analysis. Case 1 illustrates the situation when ventilation studies were markedly abnormal, but oxygenation and CO_2 excretion continued to be good. In six other cases ventilatory tests, such as the maximum breathing capacity, vital capacity, and timed vital capacity, were normal or only minimally altered, but there was significant arterial desaturation or respiratory acidosis with high carbon dioxide tensions and low pH levels.

Figure 1 illustrates an acute study of a group of nine patients with chronic lung disease, where the administration of 100% oxygen resulted in a significant increase in carbon dioxide tension and a drop in pH despite an increase in arterial oxygen saturation. Administration of 100% oxygen by intermittent positive pressure with bronchodilators increased arterial oxygen saturation still further; ventilation was significantly improved as evidenced by a drop in CO_2 tension and an increase in pH (respiratory alkalosis). A significant increase in vital capacity in the group as a whole occurred after intermittent positive pressure breathing with bronchodilators.

Figure 2 illustrates possible dangers in the administration of 100% oxygen to patients with serious lung diseases showing marked arterial oxygen desaturation at rest. The arterial oxygen rises significantly during 100% oxygen breathing, but the pCO_2 and pH change to markedly abnormal levels which, if maintained, may lead to CO_2 narcosis. Indeed, in one seriously ill patient, drowsiness occurred after 15 minutes of 100% oxygen despite an attempt at artificial assistance with the Bennett machine.

Discussion

The present study emphasizes the importance of arterial blood analysis as an integral part of pulmonary function studies. This has been clearly and repeatedly shown by many authorities who emphasize that the concept of a battery of tests of pulmonary function should not be overlooked. Since the prime function of the lung is to oxygenate blood and excrete carbon dioxide, one should logically begin testing lung function with arterial gas analysis.[3] Such studies give one indirect information of perfusion-ventilation ratios, intrapulmonary mixing of gases, and effectiveness of diffusion. Certainly these are as important as studies of ventilation, if not more so. As the present study demonstrates, there is no complete

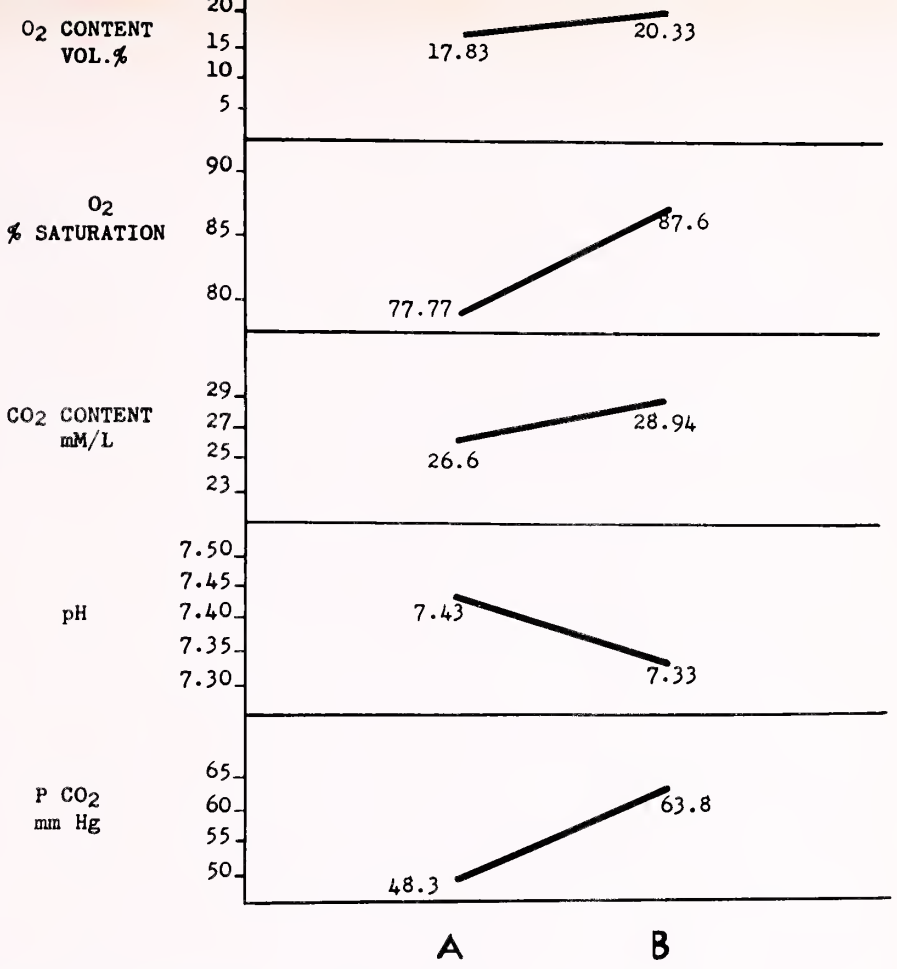


FIGURE 2. *Mean values in 6 patients with severe lung disease.*

Period A—Control.

Period B—After administration 100% oxygen for 15 minutes.

parallel of ventilation to arterial blood analysis; when one is normal, another may be markedly abnormal.

The effectiveness of intermittent positive pressure breathing in patients with lung disease has been demonstrated.[10] This study illustrates how such therapy can be evaluated by investigating changes in arterial gases and pH, as well as ventilation. Although this study demonstrated acute changes, the effectiveness of long-term management and surgical procedures can likewise be evaluated. There have also been tests devised using various types of stress and different concentrations of oxygen. Blood gas and pH analysis utilizing such techniques has proved useful in defining physiological changes in lung disease.[12] A broader survey of exercise tolerance or degree of disability can be obtained with such techniques. In practice the examinations have been useful in evaluating candidates for lung surgery, for example.

With the increase in chronic lung disease in present years, the subject of carbon dioxide narcosis is repeatedly brought up. This occurs in patients with severe lung disease, who retain carbon dioxide because of hypoventilation.[13] The cerebral centers become insensitive to changes in CO_2 tension as a stimulus for breathing, and the drive shifts to the aortic and carotid bodies in relationship to changes in oxygen tension. A significant increase in oxygenation often yields a pink patient, but one who may be in coma and barely breathing! Analysis of arterial gases and pH offers an accurate means of diagnosing this state and of evaluating therapy.

The major hospitals in Honolulu are fully equipped to perform arterial gas analysis and to measure blood pH. We would encourage fuller utilization of such studies as part of a basic plan in studying pulmonary function and in evaluating therapy. Tests of ventilation and arterial blood analysis measure entirely different parameters of pulmonary function.

Summario in Interlingua

Mesurationes ventilatori non representa un adequate substituto pro determinationes del pH del sanguine e del saturation oxygenic arterial in le evalutation del function pulmonar. In 7 ex 21 reportate casos, le ventilation esseva normal in le presentia de un grave inadequatia del oxygenation del sanguine. Le administration de oxygeno a tal patientes es potentialmente periculose.

[10] Levine, E. R., and Liu, C. K.: Emphysema in Clinical Cardio-Pulmonary Physiology, edited by Gordon, B., Grune and Stratton, New York, 1957, p. 464. Segal.[11]

[11] Segal, M. S., Salomon, A., Dulfano, M. J., and Herschfus, J. A.: Intermittent positive pressure breathing, New Eng. J. Med. 250:225 (Feb. 11) 1954.

[12] Motley, H. L.: The mechanisms of chronic pulmonary heart disease (cor pulmonale), with and without arterial hypoxemia, Progress in Cardiovascular Disease, 1:326 (Mar.) 1959.

[13] Cherniack, R. M.: Respiratory Acidosis in Pulmonary Emphysema, edited by Barach, A. L., and Bickerman, H. A., Williams and Wilkins, Baltimore, 1956, p. 357.

The President's Page



Bauer

DR. NISHIGAYA

This is my "Swan Song."

It seems that this last message is a mite easier to do as I relinquish this page to someone more articulate and capable than I.

The Association's business was not too strenuous but required searching, careful analysis of events as they arose.

With statehood, the Hawaii Medical Association has risen to its rightful stature becoming its greatness. Now all the physicians on all the islands in the State are one and any action by the Hawaii Medical Association will henceforth mean much more.

Our colleagues contributed greatly to our betterment during the past year. Those who were willing, as always, were conscientious and of great service not only to me but to the Association. To them, my thanks and eternal gratitude.

Then, again, there were those who were indifferent and contributed little or nothing. Those whose welfare was being cared for by the few even failed to contribute financially by registering for our annual meeting. Perhaps if they were aware of the fact that the registration fee helps to defray the Association's expenses during the year, they might have helped.

All in all, the year has been most fruitful and pleasant. I relinquish the position to one well versed and conscious of his responsibilities. I know under Dr. Cushnie's diligent leadership, he will ably carry us to greater heights.

Mahalo and aloha!

T. Nishigaya, M.D.

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[EDITORIALS]

Hawaii Health Survey

With the Hawaii Health Survey data tabulations underway, some indications of what the figures will show are becoming apparent. Evident already is a comparatively low rate of chronic conditions on Oahu, but a higher rate of acute conditions and a more extensive use of physician and dentist services than prevails on the mainland.

Exceptions to the general finding of lower chronic disease rates were higher rates for diabetes and asthma–hay fever. There were more diabetes at the older ages and more asthma and hay fever at the younger ages on Oahu than at the corresponding ages on the mainland.

Other chronic conditions, such as heart disease, arthritis and rheumatism, various respiratory conditions, and physical impairments, were less prevalent in Hawaii. The proportion of the Oahu population reporting one or more chronic conditions of any type was 33 per cent compared with 41 per cent on the mainland.

To a large extent, this difference is probably due to a population younger than the mainland population as a whole. In general, chronic diseases are most prevalent among older people.

On the other hand, acute conditions, normally more frequent among the young than the old, occurred at a rate of 274 conditions per 100 of the Oahu population during the survey period. This contrasts with a rate of 215 per 100 persons on the mainland.

A marked difference in the frequency of visits to dentists was observed, the rate for the people of Oahu being 2.9 visits per person per year as contrasted with 1.6 visits for the mainland population. Physician visits, also, showed a higher rate for Oahu—some 5.6 visits per person per year, on the average, in contrast to 4.8 visits on the mainland.

The survey is a cooperative project of the Public Health Service's U.S. National Health Survey, the Bureau of the Census, the Oahu Health Council, and the Hawaii Department of Health. The design of the national survey precludes obtaining separate estimates of health conditions for any single state or territory. In the case of Oahu, however, local agencies provided the additional funds needed to get the separate figures.

The procedures for obtaining the separate Hawaii statistics were initiated by Richard K. C. Lee, M.D., Director of Health, Hawaii State Department of Health. Under the direction of Charles G. Bennett and George H. Tokuyama of the Office of Health Statistics, the Department contributed funds, directed local organization, furnished travel and office facilities, and assisted in other ways.

Also contributing importantly was the Oahu Health Council. Through its Hawaii Health Survey Advisory Committee, with Mrs. John Devereux as Chairman, the Council advised on policy matters and obtained substantial funds for local expenses. The Public Health Committee of the Chamber of Commerce, voluntary health agencies, and local foundations were the major contributors.

The Hawaii Health Survey statistics were collected on the Island of Oahu during the period October, 1958, to September, 1959, in household interviews conducted by the Census Bureau for the Public Health Service. Mr. Charles Churchill, presently in charge of the 1960 Federal census in Hawaii, was the survey field supervisor.

The National Health Survey headquarters in Washington, D. C., is responsible for a first report containing some basic findings. Further analysis of the data will be carried out by the Hawaii State Health Department.

Infant Death Case Study No. 7

This male infant was delivered to a 33-year-old primiparous, Caucasian mother who was a known diabetic. The diabetes had been diagnosed two years prior to this pregnancy and was well controlled with 20 units of NPH insulin daily. She was followed by an internist during the pregnancy and the insulin was increased to 25 units of NPH insulin daily. She had 0 to 4 plus sugar in the urine, but at no time was there any acetone. The total weight gain was six pounds. The blood pressure remained at 110/70 throughout the pregnancy.

She was admitted to an urban hospital in active labor eight weeks prior to the expected date of confinement. The presentation was cephalic and there was a normal spontaneous delivery with saddle block anesthesia. A male infant was delivered, who weighed 5 pounds 11 ounces and was 17 inches in length.

At birth the condition appeared "good," but when the infant reached the nursery he was noted to be cyanotic and to have grunting respirations with some retraction of the chest. The pediatrician was then called to see the baby. At the time of examination he appeared to be an immature newborn who was moderately cyanotic, with rapid shallow respirations and retractions. The rest of the physical examination was normal. Hyaline membrane disease was suspected and he was treated with oxygen and moisture in an Isolette. Terramycin was given by injection prophylactically. He seemed to gradually improve until twenty-two hours of age, when he was found dead by the nurse.

Post-mortem examination showed:

1. Hyaline membrane disease. 2. Pulmonary atelectasis. 3. Diffuse visceral congestion.

Discussion: It was emphasized that all babies of diabetic mothers should be considered high-risk babies. Every nursery should have an area where constant observation by competent nurses is available for all high-risk babies. The pediatrician should be notified in advance in any case where the infant is expected to be a high risk and he should be in the delivery room at the time of delivery to take over the baby immediately.

The feeling was that all babies of diabetic mothers should have the stomach contents aspirated immediately after birth. It was pointed out in this regard that all babies delivered by Caesarean section should have aspiration of the stomach. Because of the increased chance of aspiration, especially after feeding, nurses should be encouraged to keep infants on the side or abdomen.

In this case, with the apparent improvement and sudden demise, the question arose as to whether this may have been a cardiac death. Digitalis may have changed the outcome, but this is an unanswerable point. Doubt was expressed as to whether any of the points mentioned would have changed the outcome in this case.

Classification: Obstetrical and pediatric death, nonpreventable.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

In Memoriam--Doctors of Hawaii--XXVII

This is the twenty-seventh installment of In Memoriam—Doctors of Hawaii.

Henry Homer Hayes

Henry Homer Hayes was born in San Francisco, California, on January 3, 1881, the son of Henry Sweet and Amy Campbell (McLeod) Hayes.



DR. HAYES

His elementary education was received in public and preparatory schools in California, one of which was the St. Matthew's Episcopal School for Boys in San Mateo, which was also attended by Prince Kuhio and David Kawananakoa. His medical degree was granted by Cooper Medical College (now Stanford University School of Medicine) in 1906. He came to Hawaii in September of the same year and became one of the first interns at The Queen's Hospital in Honolulu.

At the end of his year's internship, he had fallen under the spell of the Islands so completely he tore up his return steamship ticket and became a government physician on leeward Molokai and surgeon for the American Sugar Company, Ltd., at Kaunakakai. From 1908 to 1910 Dr. Hayes was City-County Physician for Honolulu. He returned to Molokai in 1910 to serve as government physician at Pukoo. In 1915 he established himself in private practice in Honolulu.

Of those early days on Molokai Dr. Hayes recalled that he used to make rounds on horseback. One of the horses was so wild that he had to sneak up to mount. On another occasion when he had to use a priest's mule, the mule insisted on stopping at the home of each parishioner. To reach patients in Pelekunu Valley the doctor had to swim ashore from a sampan. However, on a later visit a ship-to-shore basket tow cable was in operation.

On January 6, 1914, Dr. Hayes married Flora Allen Kaai, daughter of Judge S. W. Kaai, at South Kona, Hawaii. One son, Homer Allen Hayes, was born to the doctor and his wife.

Dr. Hayes retired in 1953, after 46 years of active practice. He estimated that he had delivered more than 2,340 babies. During his career, he served as medical attendant at Kalihi Boys' Home, Kapiolani Girls' Home, and the Quarantine Station of the Territorial Board of Health.

Dr. Hayes died August 14, 1957, in Honolulu at the age of 76.

He was a member of the Honolulu County Medical Society (life member), the Hawaii Medical Association, the American Medical Association, Honolulu Chamber of Commerce, Knights of Pythias (life member), Modern Order of Phoenix, Honolulu Yacht and Boat Club, and the Honolulu Cruising Club.

Martin Joseph O'Neill

Martin Joseph O'Neill was born in Ireland about 1862. His medical degree was granted by the Medical College of Ohio at Cincinnati in 1887.

Dr. O'Neill became physician for the McBride Sugar Company of Eleele, Kauai, in 1906. Between 1910 and 1911 he moved to Naalehu, Hawaii, where he was physician for the Hawaii Sugar Plantation Company and government physician for the West Kau district, which positions he held until 1915. He is listed in the Hawaiian Directory of 1918 as acting government physician at Kahuku, Oahu. Dr. O'Neill also served as ship's surgeon on the Canadian-Australasian ship "Niagara" and on the "President Wilson." Whether this service occurred between 1915 and 1918 or at a later date is not clear.

Dr. O'Neill died at San Francisco, California, on January 6, 1928, at the age of 66.

During his years in Hawaii, he was a member of the Territorial Medical Society.

Frederic Lincoln Morong

Frederic Lincoln Morong was born in San Francisco, California, on June 5, 1877, the son of Capt. John Campbell Morong, U.S.N., and Myra E. (Lincoln) Morong. He was descended from early colonial families, French on the paternal side and English on the maternal.

He received his elementary education in San Francisco and then attended the University of Washington for three years. His M.D. was granted by the University of California Medical School in 1901. His internship was served at the old German Hospital (now known as Franklin Hospital) in San Francisco from 1901 to 1902.

Dr. Morong married Elizabeth A. Hannigan, San Francisco, on November 26, 1902. They had a son, Frederic L., and a daughter, Myra E.

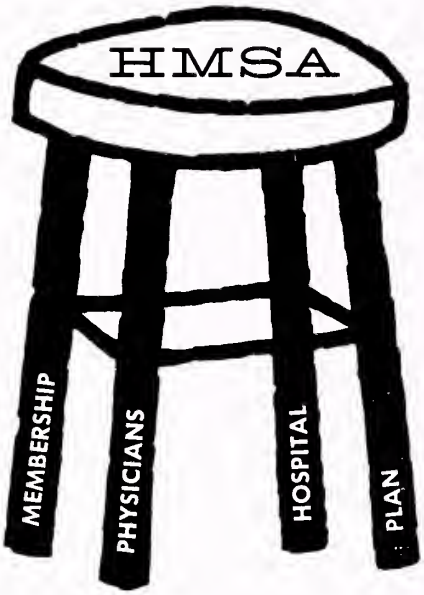
From 1902 to 1905 Dr. Morong was in private practice in his native city. After the fire and earthquake of 1906 which destroyed their home, Dr. and Mrs. Morong came to Honolulu where he joined the U. S. Public Health Service for a short time. He resigned from the Public Health Service to become plantation physician at Kahuku. In 1910 he entered private practice in Honolulu and continued in active practice until 1953, when he retired due to ill health.

For twenty-five years, Dr. Morong was a Major in the National Guard, from which he retired in 1942.

Dr. Morong died in Honolulu on February 22, 1954, at the age of 76.

He was a member of the American Medical Association, the Honolulu County Medical Society for 35 years (the Society honored him with life membership on October 8, 1948), and of the Honolulu Lodge of Elks.

Dr. Henry C. Gotshalk, in writing an obituary of Dr. Morong in the HAWAII MEDICAL JOURNAL of May-June, 1954, states: "Dr. Morong was a kindly, soft-spoken, considerate gentleman, who was intensely interested in the practice of medicine and in whom his patients had great confidence. He was greatly beloved by both members of his profession and his many friends."



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Book Reviews

Antithrombotic Therapy

By Paul W. Boyles, M.D., 131 pp., $5.00, Grune & Stratton, 1959.

A practical discussion of blood coagulation and treatment of thrombotic diseases is welcome from time to time, in view of the rapid progress made in this field during the past ten years. This little monograph serves to bring the reader up to date on such matters as the newer physiology of blood clotting, the present status of anticoagulant therapy, thrombolytic therapy, etc. However, since there are only 131 pages, including 15 pages of bibliography, to cover all of this territory, synonyms are used with great abandon and at times reading becomes exceedingly difficult and confusing. The final chapters on anticoagulant and thrombolytic therapy are quite clearly presented, however, and should be of value to anyone seeking a quick review.

THOMAS S. MIN, M.D.

Introduction to Colposcopy

By Karl A. Bolten, M.D., and William E. Jaques, M.D., 76 pp., $7.75, Grune & Stratton, 1960.

This beautifully illustrated booklet describes the technique of the procedure and correlates the gross appearance of various lesions of the cervix with their microscopic picture. The book correctly emphasizes the fact that colposcopy does not replace other diagnostic procedures, such as the various techniques of exfoliative cytology of the female genital tract, the Schiller test, biopsy, etc. The colposcope is too expensive an instrument for widespread use, and it is in line with other equipment suitable for large teaching institutions.

Hence, it would seem that the booklet itself is well worth the scrutiny of anyone who is a profound student of cancer prophylaxis. The detailed list of 127 references is indicative of the thoroughness with which the subject has been reviewed.

H. E. BOWLES, M.D.

Also Received

★Interpersonal Relationships in the Hospital

By Warner F. Bowers, 125 pp., $5.00, Chas C. Thomas, 1960.

An outspoken general surgeon offers some forceful recommendations about dealing with hospitalized patients.

The Medical Clinics of North America, Vol. 44, No. 2

Pp. 297-604 W. B. Saunders Company, March, 1960.

This is the first issue contributed by the Lahey Clinic. The papers are selected from two symposia; one on endocrine and metabolic diseases and the other on the use and abuse of corticosteroid therapy.

Enzymes in Health and Disease

By David M. Greenberg, M.D., and Harold A. Harper, Ph.D., 459 pp., $14.50, Charles C. Thomas, 1960.

We will all need to know what's in this some day. Maybe the time has come.

★ means highly recommended.

First Aid

By Warren H. Cole, 420 pp., $6.20, Appleton-Century-Crofts, 1960.

Very well done. Suitable for laymen.

Neurosurgery, Vol. II

By Major General S. B. Hays, 705 pp., $7.00, Superintendent of Documents, Washington 25, D. C.

Historical interest chiefly. A suitable gift for a neurosurgeon.

★Photography in Medicine

By Arthur Smialowski and Donald J. Currie, 330 pp., $14.50, Charles C. Thomas, 1960.

Excellent and practical manual for—you guessed it!—the medical photographer.

The Older Patient

Edited by Wingate M. Johnson, M.D., 564 pp., $14.50, Paul B. Hoeber, Inc., 1960.

Nineteen North Carolina physicians and two Texans consider geriatrics, system by system.

A Textbook of Medicine

By Russell Cecil, M.D., and Cecil Loeb, M.D., 1665 pp., $16.50, W. B. Saunders, 1959.

This reliable textbook is published every four years. The latest edition includes 36 new subjects not covered in previous editions.

Virus Virulence and Pathogenicity

By G. E. W. Wolstenholme, 114 pp., $2.50, Little & Brown, 1960.

Indispensable to virologists. Dispensable to most physicians—though epidemiologists would find many of the discussions, in particular, instructive and rewarding.

CIBA Foundation Study Group #3 Cancer of the Cervix

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., 114 pp., $2.50, Little & Brown, 1960.

Cytologists and gynecologists ought to have this inexpensive up-to-date collection of essays and always instructive and provocative discussions.

Medicine and Society in America, 1660-1860.

By Richard H. Shryock, 166 pp., $4.00, New York University Press, 1960.

The story of the first 200 years of medicine in America, carefully documented and told with skill by a professor of history.

★New and Nonofficial Drugs 1960

Evaluated by A.M.A. Council on Drugs, 753 pp., $3.35, J. B. Lippincott, 1960.

You might need this useful and reliable reference volume at any moment. Not only are there hundreds of drugs described, but there are also scores of concise

(Continued on page 694)

Notes and News

Meetings

The Mid-Pacific Tuberculosis Conference, sponsored by the Oahu Tuberculosis and Health Association, was held May 26. Local participants were **Drs. Hastings H. Walker, Robert A. Marks,** and **Major Joseph A. Hawkins.**

The Hawaii regional meeting of the American College of Physicians was addressed by **Drs. Paul Tamura, Hans Grauman,** and **Robert T. S. Jim.**

Dr. Max Levine was honored on July 1 at a testimonial dinner. Master of Ceremonies was **Dr. Masato Hasegawa.** Speakers included **Drs. Nils P. Larsen, Richard K. C. Lee, F. D. Pinkerton,** and **Colonel Hugh B. Hoeffler.**

Travelers

Travel to meetings has been considerable. **Dr. Richard Y. Noda** attended the annual meeting of the Industrial Association in Rochester, N. Y. **Dr. Norman Sloan** was at the planning sessions for the White House Conference on Aging in Washington. **Drs. Clarence W. Trexler, Robert T. Wong,** and **Albert K. T. Ho** went to the Pacific Coast meeting of the Pacific Coast Oto-Ophthalmological Society in San Francisco.

Attending the Miami Session of the A.M.A. in June were, in addition to the "official" group, (**Dr. Arnold, Dr. Richard Moore, Dr. Cushnie** and **Miss McCaslin**), **Dr.** and **Mrs. Howard Liljestrand, Dr. Richard Sia, Dr. Leo Bernstein, Dr. M. H. Lichter, Dr. Perry T. Sumida,** and **Dr. Marvin Brennecke.**

New Posts

Dr. J. Alfred Burden of Haliimaile, Maui is the new President-elect of the Hawaii Medical Association.

Dr. Edward F. Cushnie is the new President of the Hawaii Medical Association. **Dr. Gail Li** has been elected a director of the Chinese Junior Chamber of Commerce. New vice-president of the Hawaii Association to Help Retarded Children is **Dr. John Milnor. Dr. Richard K. C. Lee** has hit the jackpot on new assignments; he has been appointed to the National Advisory Committee on the selection of physicians, dentists, and allied specialists, and to the Health Resources Committee of the Office of Civil and Defense Mobilization. These two appointments are by President Eisenhower. Locally, he has been named Hawaii's first representative to the Western Interstate Commission for Higher Education. **Dr. R. Varian Sloan** was appointed to the Commission on Education of the American Academy of General Practice. He will represent Region 9, which includes Hawaii, Alaska, Washington, Oregon, Wyoming, and Idaho.

At their annual meeting in San Francisco, May 22-26, 1960, **Dr. Clarence W. Trexler** was made president-elect of the Oto-ophthalmological Society of the Pacific Coast. The Society last met here in 1954 and plans to meet here again in 1962, the latter part of June.

At the founding meeting of the organization last May, **Dr. Harry L. Arnold, Jr.,** was made one of the five Vice-Presidents of the International Society of Tropical Dermatology.

At the Miami meeting of the A.M.A. **Dr. Joseph Palma** was elected Chairman of the A.M.A. Section on Pediatrics.

Dr. Henry Gotshalk was re-elected Chief of Medical Department at The Queen's Hospital at the Medical Staff meeting last May, and Richard S. Horio was elected Associate Chief.

New Associations

Dr. Jose N. Rosal has joined the Pepeekeo Clinic. Dr. Rosal received his degree in medicine from the University of the Philippines in 1937 and was drafted by the Japanese Navy in 1942. He joined the U. S. Public Health Service in Manila after the war. In 1947 he moved to Guam where he was employed as medical officer for two contracting firms. Just prior to his arrival in Hawaii last March, Dr. Rosal was employed by the Federal Aviation Agency on Wake Island.

Dr. Felix J. Lafferty has joined the Medical Group in Waialae-Kahala. Dr. Lafferty, a general practitioner, received his degree in medicine from the University of Toronto and recently completed a year's residency in internal medicine at St. Francis Hospital.

Sports

Drs. A. Ishii and **James Cherry** shared first place honors in the Hawaii Medical Association's annual golf tournament. **Drs. Joseph Lam** and **Edwin Wong** won the Moanalua Golf Club's team best ball tournament. **Dr. Henry Yokoyama** hit a hole in one at the No. 3 hole at the Ala Wai.

New Offices

Dr. Sanford S. Katsuki has moved his offices to the Continental Building. **Dr. Ross Hagino** has become associated with **Dr. Clifford Kobayashi** in the practice of pediatrics.

JANET FORAN HARRIS, R.N., 1896-1960

Mrs. Harris was born December 29, 1896, in South Orange, New Jersey. She began to work for the Nurses & Physicians' Exchange in September, 1951. She died on May 2, 1960, as a result of injuries received in an automobile accident. She is survived by her husband, William, and one daughter, Louise (Mrs. James) Wallace.

Hawaii Medical Association

AMA Delegate's Report

At the opening session of the A.M.A. House of Delegates in Bal Harbour, Florida, June 13, 1960, President-elect Vincent Askey of Los Angeles presented President Louis Orr of Orlando with a case of Sunkist California oranges, in pretended compassion for his comparative deprivation in this regard.

At the closing session of the House on June 16, past President Orr effectively retaliated by presenting President Askey with a basket of Florida oranges—the most enormous ever seen*—picked, he said, from a tree planted the previous Monday afternoon as an emergency measure by the Florida Citrus Commission.

Between these two amusing events the House accomplished with unusual expedition a considerable amount of business, none of it particularly controversial or spectacular, but much of it of solid importance.

New President-elect is a pathologist, Leonard W. Larson of Bismarck, North Dakota, who had been a Trustee of the A.M.A. for the past 10 years and was currently its Chairman. Vice-President is William F. Costello of Dover, New Jersey.

Health Care Aid for the Aged

The Association's 8-point program was reaffirmed, and supplemented by the following paragraph:

> As an additional principle, this House submits to all citizens that where an individual is able to provide for his own medical care (from personal resources, insurance or prepayment contracts, annuities or other income), government at any level has no role. When an individual or his family is unable to provide for his own medical needs, the community has the primary responsibility for sharing in these costs. Where the community and/or the county is unable to meet these obligations, the state has a responsibility; and only as a last resort is federal government participation (administered locally) warranted.

The Board of Trustees was also urged to "initiate a nonpartisan open assembly" for the purpose of discussing these problems.

A further policy statement by the Reference Committee on Legislation and Public Relations was unanimously adopted by the House, as follows:

> Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association.

"Family Practice" Internships

A resolution that obstetrics be a required part of such internships was disapproved, since (1) gynecology is already required, (2) obstetrics must be offered by hospitals approved for such internships, and (3) there has not yet been sufficient experience with the program on which to base a statement of essentials. The problem is under continuing study.

Medical Economics

Opposition to inclusion of physicians under Social Security was reaffirmed.

A national home for indigent aged physicians was thought unnecessary at this time.

Support was avowed for organizations seeking reform of the Federal tax structure, to return sources of tax revenue to the states and "to allow American citizens to enjoy the fruits of their labors."

The House authorized preparation of comprehensive group disability insurance, a group retirement annuity program, and a pension fund for indigent physicians, at a national level.

National Foundation Relationships

All component county medical societies were advised to adopt the following statement of policies:

1. That members of the Medical Advisory Committee to The National Foundation at the Chapter level be selected from a slate of names furnished by the component medical society.
2. That it should be the function of the Medical Advisory Committee to supply a detailed report to the component society at least once annually concerning the actions of the committee.
3. That the following basic principles should govern the relationships between patients concerned, members of the component medical society, and The National Foundation's local chapter:
   a. In order for the Medical Advisory Committee to discharge its functions with The National Foundation chapter and the component medical society, the Chairman of this Committee automatically shall be a member of the

(Continued on page 708)

* They were actually grapefruit, dyed orange color.

OUR NEW PRESIDENT



DR. CUSHNIE AND FRIEND

Dr. Edward Forbes Cushnie, 61st President of the Hawaii Medical Association, came to Hawaii from Scotland in 1910. He was born in Muchalls, Kincardinshire, November 6, 1904, the year his father, William Cushnie, came to Hawaii to enter the sugar industry.

Ed's twin brother Albert (who lost his life in 1941 as a Navy Commander) studied dentistry; Ed went to Loyola Medical School, where he received his M.D. in 1939. He interned at St. Luke's Hospital in Denver, and at The Queen's Hospital, and has been in general practice since, first in association with Straub Clinic, and since 1946 in association with Drs. Dickson and Chung-Hoon.

His three brothers—Robert, James, and Ronald—are at Ewa, Honokaa, and Olaa Plantations respectively; one sister, Bella (Mrs. William Mair) is at Ewa and the other, Margaret, is Mrs. Alexis Burso of Honolulu.

Ed married Leona Schwallie, daughter of Dr. William Schwallie, in 1932, and they have three children—Douglas, who just graduated from Southern Methodist University in Texas; Charmaine, who is at the University of Hawaii; and Bruce, at Punahou.

Beside a successful career as one of Honolulu's best liked and most respected general practitioners, active in organized medicine as well, Ed has found time to conduct a successful business and to establish a country home on the heights at Pupukea, where he can indulge his favorite pastime, riding horses.

We welcome Dr. Cushnie to the highest job our Association has to offer, secure in the knowledge that he could not be better prepared for it, both personally and professionally. Aloha, Ed!

104TH ANNUAL MEETING HAWAII MEDICAL ASSOCIATION

REFERENCE COMMITTEES

No. 1—Public Health

George H. Mills
Grover H. Batten
Morton E. Berk
Chew Mung Lum
T. T. Oto

No. 2—Parliamentary Affairs

Charles S. Judd, Jr.
Edward Boone
Bernard W. D. Fong
Andrew L. Morgan
Walter S. Strode
A. Y. Wong

No. 3—Insurance and Medical Service

Ivar J. Larsen
Vernon K. S. Jim
R. D. Millard
Burt O. Wade
Verne C. Waite

No. 4—Miscellaneous Business

R. Varian Sloan
H. M. Johnson
T. Kutsunai
James Lambert, Jr.
Allan H. H. Leong
James T. S. Wong

HONOLULU
May 12 through May 15

The annual meeting for the one hundred and fourth year of corporate existence of the Hawaii Medical Association was held in Hilo. The following program was presented.

SCIENTIFIC PROGRAM

PANEL DISCUSSIONS

Medico-Socio-Economic Problems of the Aged
Moderator: Dr. Fred I. Gilbert, Jr.
Panelists: Drs. Leo Bernstein, Andrew E. Lind, Messrs. Morris G. Fox, and Kent Longnecker

The Stroke Syndrome
Moderator: Dr. A. B. Baker (University of Minnesota)
Panelists: Drs. Frank J. Bruce, Bernard W. D. Fong, John J. Lowrey, and R. F. Shepard

The Elderly Diabetic
Moderator: Dr. Peter Forsham (University of California)
Panelists: Dr. Morton E. Berk, Kikuo Kuramoto, Charles S. Brown, and Bernard J. B. Yim

Hypertension
Moderator: Dr. F. T. Darvill, Jr. (University of Washington)
Panelists: Drs. Donald W. Brown, Unoji Goto, Thomas K. L. Lau, and Chew Mung Lum

Peripheral Vascular Disease
Moderator: Dr. F. T. Darvill, Jr.
Panelists: Drs. Ralph M. Beddow, Frederick L. Giles, Carl B. Johnsen, Jr., Edward K. Lau, and Wallace W. S. Loui

Management of Heart Failure
Moderator: Dr. Peter Forsham
Panelists: Drs. A. S. Hartwell, Shigeru Richard Horio, Nobuyuki Nakasone, and Gordon F. H. Liu

PAPERS

Opening Address
Rev. Harry S. Komuro
Skin Problems in the Aging
Dr. Samuel D. Allison
Glaucoma in the Central and South Pacific
Dr. William J. Holmes
Cerebral Vascular Disease
Dr. A. B. Baker
Endocrine Problems of the Aged
Dr. Peter Forsham
Presidential Address
Dr. Toru Nishigaya

SOCIAL PROGRAM

Cocktails and Annual Banquet, Saturday evening, Oahu Country Club
Breakfast, Sunday morning, Oahu and Waialae Country Clubs (courtesy of Pfizer Laboratories)
Picnic for physicians Sunday noon at the home of Dr. Ralph B. Cloward

MEETINGS

House of Delegates: Thursday and Friday afternoons, Mabel L. Smyth Memorial Building
Woman's Auxiliary, Friday morning and afternoon at the home of Mrs. P. H. Liljestrand

HAWAII MEDICAL ASSOCIATION OFFICERS 1959-60

Toru Nishigaya, *President*
William N. Bergin, *Past President*
Edward F. Cushnie, *President-Elect*
Raymond C. Yap, *Secretary*
Frederick L. Giles, *Treasurer*
Richard T. Hata, *Vice-President from Hawaii*
H. Q. Pang, *Vice-President from Honolulu*
Vernon G. Boido, *Vice-President from Kauai*
A. Y. Wong, *Vice-President from Maui*

STANDING COMMITTEES 1959-60

Arrangements
O. D. Pinkerton
Homer Benson
Richard Chun
Frederick L. Giles
Carl B. Mason
Masato Mitsuda

American Medical Education Foundation
Min Hin Li, *Representative*

Bylaws and Parliamentary
Richard E. Ando
Herbert Y. H. Chinn
Satoru Nishijima
Clarence Y. Sugihara
Rodney T. West
H. E. Crawford
Webster Boyden
A. Y. Wong

Cancer
Grover H. Batten
Harold M. Johnson
Gail G. L. Li
George H. Nip
Walter B. Quisenberry
Irvin L. Tilden
Tokuso Taniguchi
Samuel R. Wallis
Guy S. Haywood

Chronic Illness and Aging
L. Clagett Beck
David I. Katsuki
George H. Mills
Walter B. Quisenberry
Kenneth H. Rusch
R. Frederick Shepard
Norman R. Sloan
Robert S. Spencer
Hastings H. Walker
Shoyei Yamauchi
Robert P. Henderson
Peter Kim
Edmund A. Tompkins

Diabetes
Coolidge S. Wakai
Donald W. Brown
George H. Mills
Norman R. Sloan
Louis G. Stuhler
L. M. Beers, D.P.
Max Levine, Ph.D.
Harriet Kuramoto, R.N.
Kay K. Ota
Peter Kim
Clifford F. Moran

Emergency Medical Service
Isaac Kawasaki
Leo Bernstein
Robert B. Faus
Paul W. Gebauer
Raymond H. Hiroshige
Leon E. Mermod
John H. Peyton,
(Red Cross Liaison Appointee)
Verne C. Waite
Richard M. Yamauchi
Kenneth K. Fujii
Edward B. Underwood

Chairmen's names appear in bold type.

STANDING COMMITTEES—Continued

Examining Board for Hansen's Disease

W. H. Kurashige,
Representative

Federal Medical Services

C. C. McCorriston
Grover H. Batten
William S. Ito
Ivar J. Larsen
Carl Mason
Chew Mung Lum
A. L. Vasconcellos
R. P. Wipperman
Burt O. Wade
J. Alfred Burden

Hawaiian Academy of Science

Harold W. Civin,
Representative

Health Education

Katherine J. Edgar
Samuel D. Allison
Grover H. Batten
Herbert Y. H. Chinn
Andrew C. Ivy, Jr.
Merton H. Mack
Richard D. Moore
Randal A. Nishijima
R. Frederick Shepard
Ed B. Helms

Heart

Kikuo Kuramoto
Scott C. Brainard
Bernard W. D. Fong
Alfred S. Hartwell
Norman R. Sloan
Marquis E. Stevens
Lester P. K. Yee
Mun L. Chang
Eichi Masunaga
Seiya Ohata

Legislative

Leabert R. Fernandez
Ralph M. Beddow
John F. Chalmers
Thomas Chang
John W. Devereux
Thomas P. Frissell
Clarence E. Fronk
Takeo Fujii
A. S. Hartwell
Richard K. C. Lee
Paul H. Liljestrand
Leon Mermod
H. Q. Pang
L. Q. Pang
Richard Y. Sakimoto
Theodore T. Tomita
William H. Wilkinson
Richard W. You
William N. Bergin
Marvin A. Brennecke
R. J. McArthur
S. R. Wallis
Lester T. Kashiwa
Walter S. L. Loo

Mental Health

Kenneth Rusch
Clifford T. Druecker
Richard S. Horio
Dorothy Natsui
Robert S. Spencer
Yan T. Wong
Teruo Yoshina
Nicholas Steuermann
F. H. Tong

Polio

William H. Gulledge
Thomas S. Bennett
M. M. Hasegawa
J. I. Frederick Reppun
P. M. Cockett
R. J. McArthur

Radium

George W. Henry
Samuel D. Allison
Philip S. Arthur
Hon Chong Chang
Edgar S. Childs
C. C. McCorriston
Richard D. Moore
John Ohtani
Jun-Ch'an Wang
Tetsui Watanabe
S. M. Haraguchi
P. M. Cockett
Raymond M. Otsuka

Scientific Program

Grant N. Stemmermann
Raymond G. Chang
Herbert Y. H. Chinn
Fred I. Gilbert
Nobuyuki Nakasone
Verne C. Waite
Henry N. Yokoyama
J. A. Mitchell
Vernon C. Boido
William B. Patterson

ADVISORY COMMITTEES

Board of Management Mabel L. Smyth Bldg.

Harry L. Arnold, Jr.
Masato Hasegawa
Toru Nishigaya, *Alternate*

Bureau of Crippled Children

Leabert R. Fernandez
Thomas S. Bennett
Morton E. Berk
C. M. Burgess
Duke Cho Choy
George M. Ewing
L. Q. Pang
Robert Look, D.D.S.
Robert Miyamoto
C. Hayashi
M. A. Brennecke
Clyde Ishii
William B. Patterson
Mamoru Tofukuji
Edwin D. Willett
Paul G. Stevens

Bureau of Tuberculosis

Fred I. Gilbert, Jr.
L. Clagett Beck
George W. Henry
John T. Kometani
Robert H. Marks
Noboru Nakasone
Hastings H. Walker
Francis Wong
Peter Kim
Henrietta Tompkins

Woman's Auxiliary to the Hawaii Medical Association

O. D. Pinkerton
Frederick L. Giles
H. Q. Pang

Bureau of Maternal and Child Health

C. A. Wyatt
Herbert E. Bowles
Clifford K. W. Chock
Lin T. Chun
John M. Felix
George Goto
Robert T. S. Jim
John T. Kometani
William F. Moore
Arno Mundt
Frances F. Nakamura
Satoru Nishijima
A. J. Nishimoto
Allan C. Oglesby
John I. F. Reppun
Grant N. Stemmermann
James T. S. Wong
Jack S. Woodruff
Lt. Col. John P. Fairchild
Col. Ed. A. Zimmermann
Richard T. Hata
Keith Nesting
M. A. Brennecke
Clyde Ishii
W. B. Patterson
Mamoru Tofukuji
Edwin D. Willett
Paul G. Stevens

Bureau of Workmen's Compensation

Ralph M. Beddow
Samuel D. Allison
Philip S. Arthur
Robert F. Bailey
Thomas S. Bennett
Scott C. Brainard
Donald Depp
John W. Devereux
Yasuyuki Fukushima
Ivar R. Larsen
George H. Nip
B. Allen Richardson
R. Varian Sloan
Roy T. Tanoue
Wayne W. Wong
Harold Lewis
Burt O. Wade
K. Izumi

Bureau of Venereal Disease

Samuel D. Allison
Herbert Y. H. Chinn
Edward T. Emura
Charlotte M. Florine
K. S. Fong
Linus C. Pauling, Jr.
John I. F. Reppun
Norman R. Sloan
M. H. Chang
F. H. Tong

AD HOC COMMITTEES

Association of the Professions Study

A. L. Vasconcellos
W. H. Civin
R. T. Kainuma
M. H. Lichter
R. T. West

Hawaii Medical Practice Act Review

B. A. Richardson
Samuel D. Allison
Leo Bernstein
Thomas F. Fujiwara
Richard K. C. Lee
Irvin L. Tilden
Raymond C. Yap
Howard E. Crawford
William W. Goodhue
Frank A. St. Sure, Jr.

Nominating

Edwin K. Chung-Hoon
Harry L. Arnold, Jr.
William N. Bergin
Edward F. Cushnie
Frederick L. Giles
Nils P. Larsen
Toru Nishigaya
Ah Yet Wong
Raymond C. Yap

Physicians' Aid Study

Frederick L. Giles
Herbert Y. H. Chinn
Andrew L. Morgan
Thomas Richert
H. Q. Pang
T. T. Oto
Webster Boyden

Salary Structure Study

Frederick L. Giles
Harry L. Arnold, Jr.
Edward F. Cushnie
Toru Nishigaya

SPECIAL REPORTS

Hawaii Medical Journal

Harry L. Arnold, Jr., *Editor*

Secretary's Report

Raymond C. Yap

Treasurer's Report

Frederick L. Giles

Woman's Auxiliary to the Hawaii Medical Association

Mrs. Homer Benson

PROCEEDINGS OF THE HOUSE OF DELEGATES

of the Hawaii Medical Association

104th Annual Meeting

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the President, Dr. Toru Nishigaya, at 1:10 P.M., May 12, 1960, in the Mabel L. Smyth Memorial Building auditorium, Honolulu.

Present: Drs. Toru Nishigaya, Edward F. Cushnie, William N. Bergin, Frederick L. Giles, Raymond C. Yap, H. Q. Pang, A. Y. Wong, Theodore T. Oto, T. Kutsunai, Morton E. Berk, Edward Boone, Vernon K. S. Jim, H. M. Johnson, Charles S. Judd, Jr., James Lambert, Jr., Ivar J. Larsen, Chew Mung Lum, R. D. Millard, George H. Mills, Andrew L. Morgan, R. Varian Sloan, Walter S. Strode, Verne C. Waite, James T. S. Wong, Burt O. Wade. No alternate from Hawaii was appointed to replace Robert M. Miyamoto. Dr. Pang appointed the following: Bernard W. D. Fong to replace T. H. Richert, Grover H. Batten to replace M. E. Stevens, and Allan H. H. Leong to replace Rodney T. West. Dr. A. Y. Wong appointed Joseph Sowers to replace Lester T. Kashiwa. No replacement was made for Joseph E. Andrews.

Dr. Nishigaya thanked the members for coming and commented on the good attendance. He said he was extremely proud that the doctors had given up their time for the efforts of the Association.

The minutes of the April 23, 1959, meeting were approved as published.

The President advised that it wasn't necessary to go into many details of the working of the House of Delegates. The reports of all the committees and the resolutions were sent out and members of the House have been assigned to four reference committees. The chairmen have been appointed. He urged the delegates and the alternate delegates to participate in the discussions of the reference committees and to speak for or against the proposals at that time.

Dr. Batten was asked to serve on the reference committee on public health; Drs. Wong and Fong, parliamentary affairs; and Dr. Leong, miscellaneous business.

The President asked if there were any new business to be introduced at this time. The Secretary read Resolution #4 and it was assigned to the reference committee on miscellaneous business.

Dr. Batten asked if he might have a minute to tell the members what had happened with respect to the Medical Library. The Governor had signed the bill appropriating the $175,000.00 the previous day. He thanked the members for their efforts in helping to get this legislation passed.

The reference committees were assigned meeting places and the House of Delegates was recessed at 1:30 P.M.

The second session of the House of Delegates was called to order on Friday, May 13, 1960, and the delegates were seated at 1:15.

The President asked if there were any new business to be introduced. There being none, he asked for unanimous consent to send a letter of thanks to the Wisconsin State Medical Society for the unusual resolution sent air mail special delivery which arrived the opening day of our meeting.

ACTION:

Dr. Berk moved that a letter of thanks be sent to to the Wisconsin State Medical Society for the resolution sent to us on the opening day of our 104th Annual Meeting. The motion was seconded and carried.

Dr. George H. Mills was asked to make the first reference committee report.

REFERENCE COMMITTEE ON PUBLIC HEALTH

Mr. President and members of the House of Delegates:

Your reference committee on Public Health gave careful consideration to the matters referred to it and makes the following report:

ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN

All transactions of this Committee took place at its annual meeting, January 29, 1960, at which time Dr. Connor pointed out that the Regional Heart Program financed by

U. S. Children's Bureau funds had been extended another year, until June 30, 1960. This extension was brought about by pressure from many states.

In addition to the Regional Heart Program, the Legislature has allotted $38,945 to the Bureau of Crippled Children for the 1959-1960 fiscal year for the congenital heart program. At present Bureau of Crippled Children is over-expending the budget by $6,000 in spite of our referrals to the regional heart centers. Bureau of Crippled Children had estimated in their budget presentation, 10 "open heart" and 5 "closed heart" surgeries each fiscal year. Between July 1, 1959, and January 29, 1960, 28 children had "open heart" surgery and 9 had "closed heart" surgery.

Dr. Connor added that the request in the last budget for a medical social worker position was deleted by the Governor. The Hawaii Heart Association has carried the position this fiscal year and it is their understanding that the position will terminate on June 30, 1960. The importance of a social worker in this program was emphasized. Also there is a need for a social worker to carry the load in the rheumatic fever program.

A discussion on local teams doing "open heart" surgery was held. It was pointed out that the Bureau of Crippled Children has not received any official request from either of the two teams. Bureau of Crippled Children plans to ask for consultation during the Pan Pacific Surgical meeting in October, 1960, and advice on the local team. Bureau of Crippled Children had in mind a cardiac surgeon and a pediatric cardiologist.

Dr. Ewing questioned whether a local center would qualify for Federal funds. Dr. Connor answered that it depended upon whether the regional heart center program is still in operation and whether the local center meets the approval of the U. S. Children's Bureau. She added that if this is a regional center, it would serve a designated region.

Dr. Connor reviewed the Bureau's request of the last legislative session. Bureau of Crippled Children had requested an additional 1½ physical therapists and 1 occupational therapist but the Governor recommended only 1 physical therapist. However, the Legislature did approve 2 physical therapist positions. They are now sending 1 physical therapist one week per month to rural Hawaii and 1 physical therapist three days per month to Kauai.

Dr. Connor commented that the top surgical fee is $150. She stated that this fee is low, but if California's fee schedule were used they would be operating at ½ of the present caseload.

Dr. Connor added that she would appreciate the advice of this Committee as to whether she should grant a surgeon's request of $500 for a corneal transplant. After discussion, the Committee recommended that the Bureau of Crippled Children revise its medical and surgical fee schedule to meet a percentage of the local relative fee schedule.

Dr. Connor reviewed the dental fee schedule approved by the Dental Society on February 12, 1958. She added that since the schedule lists the maximum amount that may be charged, the Bureau has asked the individual dentist for a 10 per cent discount on all bills of $40 or over.

It was pointed out that some of the dentists are complaining about the Bureau of Crippled Children's request for discount. After much discussion, the Committee recommended that the Bureau of Crippled Children ask the Dental Society to participate in polling the dentists to determine if they would be willing to give a 15 per cent discount on the fee schedule.

LEABERT R. FERNANDEZ, M.D.

Report of the Advisory Committee to the Bureau of Crippled Children:

Your reference committee recommends that since there is a question of limitation of Bureau of Crippled Children funds and since funds for a few cases are available at The Queen's Hospital, and since one team has demonstrated its capacity to do the work and has met the requirements, every effort should be made, with the consent of the patient's family physician, to allow the teams at The Queen's Hospital and at St. Francis Hospital to do cases locally in order that these cases will be prepared for the examiners by the time of the Pan-Pacific Surgical Association meeting in the fall.

Whenever possible, all cases that can be done locally should be done for the following reasons:

1. Less expense to taxpayer.
2. Psychologically better for the family if done at home.
3. Economically more feasible for the family.
4. Provides surgery for locally qualified men.

This reference committee strongly recommends that at least one orthopedic surgeon be on the Advisory Committee to the Bureau of Crippled Children.

In discussing surgical fees for corneal transplants we recommend that the fee be relative to any other fee in the particular surgical subspecialty. It is the opinion of the committee that $150.00 is too low as a maximum surgical fee.

ACTION:

The Chairman moved adoption of this portion of the report.

Dr. Leong asked about the time limit for the cardiac teams, and it was explained that at the time of the Pan Pacific Conference there will be two men here who can make the inspection. If the teams are not ready then, they will not be able to qualify the teams for any Federal funds. Dr. Cushnie asked what fee the committee recommended for a corneal transplant. Dr. Mills advised that the Bureau of Crippled Children objected to the $500.00 fee asked; they felt it was too high. It was suggested that they use the relative value fee schedule to arrive at an equitable fee for a corneal transplant. Dr. Berk said that at the present time $150.00 is the maximum fee they pay any surgeon no matter what procedure is done and the reference committee felt that it was wrong for one sub-specialty to ask for $500.00; that it might be unfair to other surgeons.

The report was adopted.

EXAMINING BOARD FOR HANSEN'S DISEASE

During the past year there were no cases for consideration that came up before the Examining Board for Hansen's Disease.

There is no recommendation or suggestion to be made by the Committee.

W. H. KURASHIGE, M.D.

Report of the Examining Board for Hansen's Disease:

Your reference committee recommends this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HEALTH EDUCATION COMMITTEE

Two programs were conducted, one on September 16, 1959, entitled "One Man's Poison Another Man's Meat"—participants: Drs. Caver, Chun Ming, and Sugihara. The second program was on "Hansen's Disease" on October 10—KONA, Channel 2, and KALA, Channel 7, Maui. Participants: Drs. Chung Hoon, Hedgecock, Hirschy and Arnold Jr.

Two more programs, on the eye, were planned for November and December, but it was not possible to obtain KONA station time. In the meanwhile the station made an offer of the use of video tape for Medical Association programs and the Council voted "that the use of video tape be approved for one year and that the Health Education Committee work out the best system of implementing the program and be authorized to use their judgment as to the best manner of procuring and utilizing the tapes."

Unfortunately the Chairman was unable to continue work on the Committee any longer and the matter of implementing the program was not solved. It is hoped that the work of the Committee can continue.

KATHERINE J. EDGAR, M.D.

Report of the Health Education Committee:

Your reference committee recommends that a chairman

of the Health Education Committee be appointed now to proceed with preparations for videotapes. This medium is excellent for good public relations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HEART COMMITTEE

One meeting was called during 1959. The Committee met on October 27, 1959, at Mabel Smyth Building. The following recommendations made by the Department of Health were approved.

(1) The Bureau of Crippled Children cares for children with rheumatic fever and rheumatic heart disease, promoting the prophylactic use of penicillin to prevent recurrence. The now approved recommendation is "Any patient who has a history of rheumatic fever or chorea, or who shows evidence of rheumatic heart disease should be given continuous prophylaxis throughout life." However, many of those who once received treatment have been lost to view, partly because of reaching adult status. It is suggested: (a.) A clerk go through the files of the Bureau of Crippled Children to locate records of delinquent cases. (b.) A social worker locate the cases and if under medical care, check with physician as to whether status is satisfactory and if we can give any further service. If not under medical care, if not indigent, try to get patient to his doctor; if indigent or medically indigent, arrange for clinic or government physicians care; arrange for provision of drugs, if needed.

(2) A demonstration program on work simplification for those who deal with cardiac patients in their homes.

(3) Employment of a physical therapist who could instruct and assist in rehabilitation programs for cardiac and CVA patients in nursing homes or patients' homes. She would also assist public health nurses in their work with cardiac patients.

KIKUO KURAMOTO, M.D.

Report of the Heart Committee:

Your reference committee recommends adoption of this report with the following corrections:

1 b. It is suggested that the 3rd and 4th words of this sentence "social worker" (locate the cases) be corrected to read "a nurse."

3. It is suggested that the 3rd, 4th, and 5th words of this sentence "a physical therapist" (who could instruct . . .) be changed to "a team."

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD HEALTH (also THE MATERNAL AND INFANT MORTALITY STUDY COMMITTEE)

The objectives of the Committee are to serve as an advisory committee to the Bureau of Maternal and Child Health of the State Department of Health; and also to function as a maternal and infant mortality study committee. The purpose of the latter might be defined as a committee to study by specific and confidential analysis all factors involved in maternal and infant deaths in order that (1) avoidable factors in maternal and infant deaths may be reduced or eliminated and (2) better maternal and infant care may be assured through improvement in teaching and practice.

Major activities of the Committee for 1959 were as follows:

Since the January, 1959, meeting, 12 meetings have been held to discuss 17 maternal and 17 infant deaths.

The March meeting was on Kauai, at which Committee members discussed management of toxemia of pregnancy, and pneumonitis of the newborn.

The October meeting was on Maui where discussion centered around toxemia of pregnancy, and sudden infant deaths.

Letters summarizing Committee discussion of individual deaths were sent to the attending physicians.

Reprints of an article on the dangers of pitocin were circulated; and also an Academy of Pediatrics statement of "Hazards of Antibiotics in Premature and Fullterm Newborn Infants."

The Committee reviewed the "Revision of Midwife Legislation" for the Bureau of Maternal and Child Health.

Following is a comparison of 1958 and 1959 maternal* deaths:

	1958	1959
Gross maternal* deaths	9	12
Directly obstetrical	5	4
Indirectly obstetrical	2	3
Due—intercurrent disease	1	2
Non obstetrical	2	3
Preventable obstetrical deaths	3	5
Probably preventable	3	0
Not preventable	2	1
Not determined	1	1

* Pre—Intra—or Postpartum 90 Days

Concerning the activities of the Infant Mortality Subcommittee of the Committee as a whole, one of the goals for 1959 was to publish cases studied in the HAWAII MEDICAL JOURNAL. This has been accomplished and will be a continuing project in 1960 for the Committee. In 1958 five cases were studied by the Committee. In 1959, we studied, in detail, 17 cases. Cases have been picked by diagnosis and general interest. Of the 17 cases studied, ten were classified as combined obstetric-pediatric deaths and seven as pediatric deaths. Nine of the cases studied were classified as preventable deaths; however, five of these were felt to be preventable on an academic rather than practical basis.

The Committee wishes to make the following recommendations for House of Delegates consideration:

(1) That more publicity be given to the profession about availability of consultation by specialists through the Bureau of Maternal and Child Health for patients who cannot afford private consultation—on request by the attending physician by telephone (to the Bureau) and from a list of specialists.

(2) That the House of Delegates instruct the Legal Committee of the Hawaii Medical Association to assist in formulation of legislation to prevent subpoenas of medical study committee records and findings. This should refer to this particular Committee (Maternal and Infant Mortality Study Committee) and others with similar aims, activities, and purposes such as hospital tissue committees.

CLARENCE A. WYATT, M.D.

Report of the Advisory Committee to the Bureau of Maternal and Child Health:

Your reference committee studied the two recommendations and strongly approves of both. It is our impression that the second recommendation should be approached with great care and should be referred to the Legislative Committee for sound legal advice. Information relative to this second recommendation can be obtained from Dr. Katherine Edgar who has on file the procedures which were used in Minnesota to eliminate this problem.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

POLIO COMMITTEE

The Polio Committee during the past year has had no formal meetings. There have been several informal discussions among the members, at least the members on this Island, and we have not felt the need for a formal meeting.

It was not felt necessary to take any stand on the question of the fourth polio shot because it is now well established that this is a standard procedure.

The chairman of this Committee seriously questions whether there is any need for a Polio Committee unless there is some definite mission for it to accomplish.

WILLIAM H. GULLEDGE, M.D.

Report of the Polio Committee:

Your reference committee recommends that the Polio Committee continue because of pertinent legislation which may be forthcoming on polio.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RADIUM COMMITTEE

The following is the report of the Radium Committee for the year 1959-60.

1. It was recommended to the Department of Health that they secure additional instruments for the handling of radium, a lead protective shield, and a lead safe. These items have been purchased by the Department of Health.

2. It was recommended unanimously by the Committee that a radiation physicist or radiologist be designated by the Department of Health to act as their agent. This individual would be responsible for the care and safety of the radium, as well as for its dispensing and the checking of its return. Since this procedure involved no change in reference to the physicians or patients in the various islands of Hawaii, passing by the House of Delegates did not seem to be required This method of handling will promote increased safety to those handling and caring for the radium. Also that the radium issued is of the presumed strength will be certified. This procedure is acceptable to the Department of Health and is at present being favorably considered by them, although as yet it has not been implemented.

3. Resolution #23 from the A.M.A. concerning surveys of radiological diagnostic equipment was reviewed. The Department of Health for the last several years has a separate section of radiation hygiene under Mr. Iwashita. They have been inspecting and checking fluoroscopic and radiographic equipment of all physicians and dentists. Because this system already exists and has proved to be satisfactory, there seems to be no need for a new duplicating inspection system by the society. We felt that this resolution required no further action.

4. Two members representing the Radium Advisory Committee and the Medical Association attended the "Emergency Radiological Assistance Plan" meeting. It is the feeling of the Committee that the small and low level amounts of radioactive material used by civilians of Hawaii is insufficient to warrant the type of organization now present on the West Coast. The purpose of teams of this sort is to care for accidental dissemination of radioactive material other than radium and radon. At present the only major or sizable amounts of radioactive material in Hawaii are in the hands of the military, and they have their own assistance teams to care for any accidental spill of such. If nuclear reactors for power are introduced to the State, it would be necessary to reconsider and presumably form such an emergency team.

5. It was recommended to the Department of Health that they purchase a multiple source intra-cavitary radium applicator (Holter applicator). This was approved and secured.

GEORGE W. HENRY, M.D.

Report of the Radium Committee:

Your reference committee feels the recommendations to the Health Department were excellent and will promote greater safety in the handling of radioactive material. The reference committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF TUBERCULOSIS

This Committee has no recommendations to make.

FRED I. GILBERT, JR., M.D.

Report of the Advisory Committee to the Bureau of Tuberculosis:

Your reference committee recommends acceptance of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF VENEREAL DISEASE

The venereal disease activities of the Department of Health are now carried out by the Bureau of Adult Health. This Committee might appropriately be re-named Advisory Committee on Venereal Disease to the Bureau of Adult Health.

The VD Advisory Committee met once during the year. Indications are that there is no change in the incidence of gonorrhea over previous years. While there have been a few cases of early syphilis, this disease does not appear to be a serious problem.

The Committee discussed certain technical aspects of the VD clinics and in general recommended that the VD clinic use for both treatment and prophylaxis of gonorrhea 2.4 million units of a long-acting penicillin preparation.

There was also discussed the possibility of discontinuing the VD clinic and having the clinic services performed by the outpatient clinics of the several hospitals.

The follow-up of certain serologic tests was briefly discussed.

S. D. ALLISON, M.D.

Report of the Advisory Committee to the Bureau of Venereal Disease:

Your reference committee recommends that the Venereal Disease Clinics return to the outpatient departments of the various hospitals where outpatient departments exist. Financial arrangements between the Health Department and such outpatient facilities should be consummated.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

The Chairman moved adoption of the report as a whole. It was adopted.

Dr. Charles S. Judd, Jr., was asked to make the second reference committee report.

REFERENCE COMMITTEE ON PARLIAMENTARY AFFAIRS

Mr. President and Members of the House of Delegates:

Your reference committee on parliamentary affairs gave careful consideration to the matters referred to it and makes the following report:

ARRANGEMENTS COMMITTEE

The Arrangements Committee met eight times separately and two times with the Scientific Program Committee.

Various subcommittees were appointed consisting of Dr. F. L. Giles, Scientific Exhibits; Dr. James Marnie,* Golf; Dr. Carl Mason, Banquet; and Dr. Masato Mitsuda, Picnic.

The Committee functioned efficiently throughout the year.

Much thought and effort has been given to promote more interest and attendance at our annual meetings. An actual canvassing of membership by telephone will be carried out. The Committee deplores the past lack of interest of our members in attending our own convention and the lack of interest in the proceedings and decisions of our House of Delegates.

It is recommended that the succeeding Committee meet very shortly after this convention meeting and that immediate action be taken on a location for the next convention, this being the most important item for decision.

The Chairman wishes to thank those members of the Committee who have given so unselfishly of their time and thinking in promoting this annual affair. Thanks are extended also to our Executive Secretary, Miss Lee McCaslin.

O. D. PINKERTON, M.D.

Report of the Arrangements Committee:

Your reference committee moves acceptance of this report and recommends that the new Arrangements Committee be nominated as soon as possible after this meeting, and instructed to select a convenient site for 1961.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

* Resigned March 2.

BYLAWS AND PARLIAMENTARY COMMITTEE

Your Committee made a review of the various amendments to the constitution which have been made over the past few years and reached the conclusion that it would be imperative to review the constitution and bylaws of the American Medical Association as well as those of other state medical associations.

This preliminary study has been completed and the drafting of the revised constitution and bylaws will be undertaken during the coming year. It is expected that final action on the revised constitution will be completed within the next few months.

RICHARD E. ANDO, M.D.

Report of the Bylaws and Parliamentary Committee:

Your reference committee recommends that the President appoint some or all of the present committee to serve next year in order to provide continuity.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE COMMITTEE

The Legislative Committee met Friday afternoons during the two sessions that have taken place since the last meeting of the House of Delegates.

At the special session, our main concern was the separation of the Department of Health and the Department of Social Services. There was a great deal of effort put forth on the part of the committee to get the recommended amalgamation rescinded and although the Democrats of the House of Representatives invoked the unit rule on this item, the Senate voted to separate the two departments and this decision held in the conference committee and became fact. During this session one dinner was given for the Legislature at the Waialae Country Club. Total attendance was 121, 41 legislators and 80 doctors.

During the 1st State Legislature our main concern was securing an appropriation for the Medical Library and although the session was not concluded in time to report on the final actions, it would seem that the chances of getting this money are very good.* The Ways and Means Committee and their wives as well as the Finance Committee were entertained at two seperate tea house parties where, because of the expense involved, the Medical Association was represented by only a few members of the Committee. In addition, a dinner was given for the entire Legislature at the Reef Hotel at which time the pharmaceutical detail men put on a skit. The attitude of the legislators at the second dinner seemed to be somewhat more relaxed and informal than at the first affair. Total attendance was 96, 36 legislators and 60 doctors. It is the opinion of this committee that these dinners have proved most worthwhile and should be continued. It is proposed that before the end of this session, the two public health committees should be entertained. If this proves feasible, it will be done.

A bill providing for health insurance for government workers was introduced in each house. This was turned over to the Honolulu County Medical Society's Medical Care Plans Committee for study. This bill was amended several times and to date has passed three readings in the Senate and two in the House, but it is anticipated that the bill will not be passed out of the Finance Committee before the end of the session.† In its last draft it did not provide for government contribution but merely allotted $25,000.00 for the activation of a Commission to contract for insurance on a group basis. The Commission is to be made up of the members of the State's Retirement Committee plus one substitute who is engaged in the insurance business to be appointed by the Governor. This was a comparatively quiet session and the Committee reviewed only forty bills, some of which were duplications. Although the session is not over, it seems certain that none of the bills we opposed will be enacted into law.

* $175,000 was appropriated.

† It was not.

The most actively opposed bill was a proposed amendment to the Medical Practice Act which was introduced in both Houses. Several of the members of the Board of Medical Examiners joined in giving testimony opposing changes in the Act to permit foreign medical school graduates to take a license under certain detailed provisions. The Committee felt that it was not fair to the Board of Medical Examiners to have the law changed each session for the benefit of a few individuals.

Before the First Legislative session opened the State Committee added the members of the Honolulu County Medical Society to its roster and made the county chairman, Dr. Ted Tomita, the first vice-chairman of the State Committee. Dr. Thomas Frissell was named second vice-chairman.

The Second State Legislature promises to be extremely active and the committee feels that a full time employee should be retained during the session to cover the activities at the Palace and to take over some of the tremendous amount of paper work that will result.

LEABERT F. FERNANDEZ, M.D.

Report of the Legislative Committee:

Your reference committee recommends approval of the report of the Legislative Committee and makes the following recommendations:

1. That members improve their attendance at meetings with legislators.

2. That the Legislative Committee be empowered to employ an individual full-time, during the Second State Legislature, to cover the activities at the Palace and to take over some of the great amount of paper work that will result.

3. That the Hawaii Medical Association appropriate $1,000 to be used to pay for this employee.

4. That specific action be taken by the Legislative Committee to keep the membership of the Hawaii Medical Association well informed as to the content of all bills pertaining to medical practice when these bills are first introduced.

ACTION:

The Chairman moved adoption of this portion of the report.

Dr. Mills asked how the figure of $1,000 was arrived at. Dr. Judd said when it was discussed it was noted that a legislative session might last three months and that the average going rate for a person to do this work would be roughly $300 a month. Dr. Leong wanted to know if this person were to read and digest the bills. He asked if he would act as a lobbyist or as a secretary to do the running around. He noted that in the last paragraph of the Legislative Committee's report they asked for someone to read over every bill introduced, to pick up bills pertaining to the medical profession, and to bring them to the attention of the Legislative Committee. Dr. Berk asked what sort of an individual should be hired. Dr. Nishigaya thought that the Legislative Committee had in mind a retired physician. Mr. Johnson asked if Mr. Kennedy would not be there inasmuch as he is a member of the House. Dr. Nishigaya said we had a great deal of help from him and from Mrs. Devereux but this is not adequate. Mr. Kennedy spoke on the tremendous amount of paper work that has to be done. He said that up until now he has in essence been taking the place of a lobbyist and that he hoped he would always be in agreement with the views of the Medical Association. In addition the Association needs someone who can screen the bills and present them to the Legislative Committee in a form that they can use. Then the Committee can go about making a decision on what to do about these bills. He said it would be more of a secretary's work than that of a lobbyist. Dr. Millard asked about the possibility of getting a newspaper man who is assigned to cover the Legislature. Dr. Leong said that Mr. Kennedy had described the duties of this person and he thought it would take more than a secretary, prob-

ably an experienced politician or an attorney. He didn't think things could be trusted to a secretary who you could get for $1,000. Dr. Nishigaya thought it could be left to the discretion of the Legislative Committee and the chairman himself could use the funds in a very efficient manner. He noted that Dr. Cushnie had spoken to Dr. Fernandez about the chairmanship and he had agreed to continue in this capacity. Dr. Yap said that having served as chairman of this committee in prior years, he thought that the person they should have would be a clerk who has been in the Legislature. He explained the routine of the House and Senate. Dr. Cushnie said he thought that maybe some day you would need a lobbyist but not now; just now we need a clerk until we can see where we are going. Dr. Bergin said he couldn't see any reason why this recommendation couldn't be passed in its present form; that the Council could adjust the amount if changes become necessary.

This portion of the report was adopted.

HAWAII MEDICAL PRACTICE ACT REVIEW COMMITTEE

This Committee did not have any immediate need for change in the present legislation. There was one bill introduced in the first State Legislature to liberalize the licensing of foreign trained physicians (HB 392, SUM 105). However, this was opposed strenuously.*

B. ALLEN RICHARDSON, M.D.

Report of the Hawaii Medical Practice Act Review Committee:

Your reference committee recommends adoption of this report and also recommends that this ad hoc Committee continue in office. It recommends that the Committee review the present Act and make recommendations for improvements. Specifically, your reference committee recommends that improvements be made in the Act to provide for medical care by licensed physicians only or by practitioners who are equally competent medically. Also, that various local medical care plans be studied with an eye to improved medical practice and the prevention of the establishment of plans deleterious to the standard of medical practice in the state.

ACTION:

The Chairman moved adoption of this portion of the report.

Dr. Berk asked what was meant by the reference committee's phrase that the Act provides "practitioners who are equally competent medically." Dr. Judd said this was an attempt to tighten the reins and maintain the standards.

This portion of the report was adopted.

SALARY SURVEY STUDY COMMITTEE

The meeting was held at the Mabel Smyth Memorial Building, March 1, 1960, at 4:30 P.M. Present were: Doctors Arnold, Cushnie, Nishigaya, and myself.

The matter of starting salaries was first discussed and the following was decided upon:

	STARTING	TOP
Executive Secretary	$8,400.00	—
Stenographer	250.00	$385.00
Part-Time Help	1.00	1.25

It was noted that the executive offices are open from eight to four, five days a week, with an hour for lunch. In view of this short work week, thirty-five hours, no overtime is paid to the stenographer who is occasionally called upon to work past four o'clock. In addition, the office is closed on all State holidays as listed by the Chamber of Commerce.

It was decided that one-third of the stenographer's time and one-third of the executive secretary's time would be charged to the JOURNAL expenses.

* And did not pass.

Not mentioned in the meeting was the matter of Christmas bonuses. For the past year the HMA offices followed the pattern set by HCMS and BME and paid the employees two per cent of their annual earnings.

F. L. GILES, M.D.

Report of the Salary Survey Study Committee:

The reference committee recommends that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCIENTIFIC PROGRAM COMMITTEE

The Scientific Program Committee of the Hawaii Medical Association has held several meetings with a view towards arranging a program for the next convention of the association in May, 1960. We have decided to concentrate the subject matter of the convention in the field of geriatrics. We have acquired three speakers from the Mainland. These are Doctor Peter Forsham, who will discuss the endocrinologic aspects of aging; Doctor A. B. Baker, who will discuss the neurological aspects of aging; and Doctor F. T. Darvill, who will discuss hypertensive cardiovascular disease.

As in the previous convention, the program will be presented in a symposium fashion with local doctors participating. It is hoped that the program will meet with the satisfaction of all concerned.

GRANT N. STEMMERMANN, M.D.

Report of the Scientific Committee:

The reference committee recommends that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SECRETARY'S REPORT

The total membership of the Association, in all classes, as of December 13, 1959, was 605, of which 521 (12 more than last reported on March 31, 1959) are regular dues paying members. The total number of associate members decreased by two while the total number of life members increased by 8. The total number of physicians licensed to practice medicine in Hawaii as of December 31, 1960, was 832 (33 more than last reported) of which 632 reside in Hawaii (25 more than last reported).

As of December 31, 1959, there were 467 active members of the American Medical Association an increase of only 4 over December 31, 1958.

There is still inconsistent membership reporting which it is hoped will be corrected by the proposed revision of the bylaws.

By counties the membership is made up as follows:

	REG.	LIFE	MIL.	HON.	ASSO.	RET.	TOTAL
Hawaii	47	5	—	—	1	—	53
Honolulu	424	20	3	8	35	3	493
Kauai	14	—	—	—	—	—	14
Maui	36	1	—	—	—	—	37
	521	26	3	8	36	3	597

The following is a summary of some of the more important actions taken by the Council during the three meetings it has held since the last annual meeting:

On July 23, 1959, the Council (1) authorized the President to sign the Medicare contract and to advise the American Medical Association that the Hawaii Medical Association would like to have a congressional hearing on Federal medical care of veterans with nonservice connected disabilities; (2) voted to waive the dues of members automatically after similar action by a county society.

On November 18, 1959, the Council (1) confirmed the written ballot taken which gave (a) official approval of the separation of the Department of Health and the Department of Social Services, (b) changed the dates of the annual meeting, and (c) authorized expenditure of funds to cover

the hospitality room co-sponsored with the Honolulu County Medical Society at the Western Conference of Prepaid Medical Plans; (2) voted to give the Woman's Auxiliary the unspent portion of their allotment; (3) approved subscribing to the Oahu Health Council as a supporting member; (4) supported the continued work of the cytology laboratory; and (5) urged the reappointment of Dr. Richard K. C. Lee as Director of the Department of Health.

On March 4, 1960, the Council (1) referred to Honolulu County the proposal that a survey be made to determine the number of hours local physicians contribute yearly to the care of indigent and medically indigent patients; (2) dropped the idea of publishing a roster of all members; (3) approved the budget for 1960; (4) appropriated funds to permit the Health Education Committee to use video tape in producing their TV shows; (5) approved increases in Association staff salaries and instructed the president to appoint a committee to work with the Honolulu County Medical Society in working out equitable salary schedules; and (6) gave permission to Dr. Ira Hiscock to circulate the members to get their opinion relative to his health survey.

RAYMOND C. YAP, M.D.

Report of the Secretary:

Your reference committee recommends acceptance of the Secretary's Report with the correction in the first paragraph, December 31, 1959, instead of December 31, 1960. Your committee recommends that the county society secretaries report changes in membership status promptly.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TREASURER'S REPORT

The General Fund as of December 31, 1959, was $27,016.03* which included cash on deposits in savings and loan associations, cash on hand in the bank, inventory, liabilities, furniture, etc. This represents a net increase of $3,663.47 over the amount reported December 31, 1958. A transfer of $5,000.00 from the checking to the savings account was made early in January, which should result in a higher income from interest. The following is the budget approved by the council at its meetings on March 4, 1960.

Income	1959 BUDGET	1959 ACTUAL	1960 BUDGET
Dues	$17,500.00	$17,682.00	$19,050.00
JOURNAL	2,800.00	1,704.36	1,710.00
Annual Meeting	1,750.00	1,851.07	3,150.00
Miscellaneous	300.00	347.82	350.00
Interest	615.00	670.48	850.00
	$22,965.00	$22,255.73	$25,110.00
Expenses			
AMA Convention	$ 3,900.00	$ 3,854.85	$ 4,100.00
Audit and Legal	700.00	700.00	1,000.00
Automobile expenses	600.00	600.00	600.00
Library	100.00	100.00	100.00
Donations	300.00	325.00	330.00
Entertainment	100.00	186.55	200.00
Insurance	100.00	24.00	100.00
Health Ed. Com	600.00	141.90	1,150.00
Miscellaneous	300.00	86.55	200.00
Postage	450.00	900.44	950.00
Rent	1,850.00	1,848.00	1,850.00
Repairs & Maint	50.00	57.56	150.00
Salaries	8,700.00	9,593.16	12,940.00
Stationery & Sups	400.00	525.06	600.00
Subscription & Dues	150.00	237.20	320.00
Taxes	315.00	220.77	350.00
Tel. & Tel	700.00	784.52	800.00
Council Travel	900.00	1,266.50	650.00
Per Diem	—	—	230.00
Meals	—	—	260.00
	—	—	120.00
President's Contin	1,000.00	—	500.00
Leg. Com	250.00+ †753.80	383.17	1,000.00
Furn. & Fix	550.00	533.97	1,250.00
Expenses over normal budget			
Roster	—	—	—
Statehood Ad	960.00	640.00	—
Woman's Aux	500.00	500.00	—
Bylaws Printing	—	—	100.00
Payment to Hon. Co	50.00	50.00	—
	$23,525.00	$23,559.20	$29,850.00
Less reimbursement from the JOURNAL on prorated items only	—	4,462.21	5,650.00
TOTAL EXPENSES	$23,525.00	$19,096.99	$24,200.00

In line with the recommendation of the House of Delegates, certain expenses such as salaries, taxes, rent, telephone, etc., were prorated and charged to the JOURNAL in order to give a more accurate financial picture of this activity. The expenses are included in the budget figures and the amount prorated is indicated as a reimbursement. This method of accounting is used for two reasons: (1) the auditors recommend it as good accounting practice, and (2) it makes the budget more easily definable by the members as all expenses have to be shown in one place and cannot be charged to one activity one year and another the next. The following is a breakdown on the JOURNAL expenses and income:

Income	1959 BUDGET	1959 ACTUAL	1960 BUDGET
Advertising	$26,575.00	$25,020.46	$31,000.00
Sales & Subscriptions	3,455.00	4,110.00	4,000.00
	$30,030.00	$29,130.71	$35,000.00
Expenses			
Commission Paid	$ 650.00	$ 683.17	$ 700.00
Discounts Allowed	2,000.00	2,004.83	2,500.00
Auto Allowances	—	300.00	300.00
Miscellaneous	150.00	39.59	40.00
Postage	300.00	205.33	250.00
Printing	24,000.00	20,035.13	24,000.00
Rent	—	924.00	920.00
Salaries	—	2,866.50	4,000.00
Telephone	—	240.00	250.00
Taxes	—	71.71	100.00
Translations	—	27.10	30.00
Stationery & Supplies	100.00	28.99	200.00
	$27,200.00	$27,426.35	$33,280.00
Net Income	$ 2,830.00	$ 1,704.36	$ 1,710.00

The annual meeting income figure is predicated on a total registration of 200 doctors.

	1959 BUDGET	1959 ACTUAL	1960 BUDGET
Registration	$ 650.00	$ 69.11	$1,050.00
Banquet	—	11.43	—
Picnic	—	(22.50)	—
Breakfasts	—	3.87	—
Exhibitors	1,100.00	1,789.16	2,100.00
	$1,750.00	$1,851.07	$3,150.00

House of Delegates expenses are charged to registration as well as most of the other miscellaneous expenses. A larger annual meeting income is expected for 1960 as a result of extra promotional efforts made in behalf of our first meeting under statehood which should result in increased attendance and a larger number of exhibits. It was with a great deal of regret that it was found necessary to hold the meeting outside of the Mabel Smyth Building but this was made mandatory because of the need for additional space. The cost of holding the meeting at the Dome should be slightly less than if it were held in Mabel Smyth.

The bookkeeping system instituted in 1958 is still in operation under the supervision of the same accountant, Mr. Leslie Ajifu. Mr. Ajifu spends from 11 to 15 hours every month in the office bringing the accounts up to date and submits a monthly report. Mr. Ajifu has advised that he is spending more time on this work than it was at first anticipated and the Council therefore granted him an increase from $50.00 to $75.00 a month.

Since Mr. Frank Hough's services as auditor have been most satisfactory it is recommended that he be retained. I should like to call attention to the fact that the fee Mr. Hough is paid for his services is far below the actual expenses he incurs in making his audit. In addition his services have been freely offered throughout the year. His valuable advice and guidance are very much appreciated.

* These figures were not the final figures and the audit figures show some minor changes; i.e., General Fund, $27,044.03.

† Money transferred from Public Service account not included in budget.

It is not recommended that there be any increase in dues this year nor is such an increase contemplated within the next few years. Although the Association's expenses will increase because of the general inflation and because of the increased services offered to the members, it is hoped that the increase in membership, together with increased efforts to make the JOURNAL and the Annual Meetings more profitable, will offset the higher operational costs.

FREDERICK L. GILES, M.D.

Report of the Treasurer:

Your reference committee reviewed the Treasurer's report and recommends acceptance.

ACTION:

The Chairman moved adoption of this report as a whole. It was adopted.

The Chairman moved adoption of this portion of the report. It was adopted.

Dr. R. Varian Sloan was asked to make the third reference committee report.

REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Mr. President and Members of the House of Delegates:

Your reference committee on Miscellaneous Business gave careful consideration to the matters referred to it and makes the following report:

AMERICAN MEDICAL EDUCATION FOUNDATION

It pleases me to report that this campaign to support all medical schools, both state and private, has shown an increase of 17.2 per cent since 1958, and a 36.7 per cent increase since 1957.

Because it is a voluntary affair, and there is no budget for this Committee, it is my personal feeling that the doctors of Hawaii are doing creditable contributing.

Again, the medical graduates of private, endowed schools contributed more than men who came out of state supported medical colleges.

A great number of contributions direct to these medical institutions do not and have not throughout these years been reported to the AMEF. Therefore, we do not have a better picture of the doctors of Hawaii who contributed to the medical schools.

As of 1958, the amount of $1,767.48 was shown in the records as having been given by 50 doctors.

For the year of 1959, 83 doctors (an increase of 33 doctors) contributed $3,910.00. This showed a marked interest in this effort to help medical education. Yet, this does not picture the amount of money sent direct to respective medical schools. I do have a feeling that the 1959 figure should be triple, if the private institutions report to the AMEF.

My recommendations are: (1) If contributions are made, it would not be too difficult for an individual doctor to notify the AMEF, if a contribution has been made. (2) Men who came from state supported medical colleges should earmark their contribution for the medical school, and not for the whole university. (3) A small budget should be given to the AMEF of Hawaii in order to permit soliciting Foundations, Drug Supply Houses, and other Merchandise and Industrial firms for support of the AMEF since the Western Interstate Commission for Higher Education has included the University of Hawaii, and our high school graduates in the western conference medical schools as residents and they do not pay non-resident tuitions. (4) If such a program is inaugurated, more publicity has to be given to the public.

The Committee wishes to thank all the doctors of Hawaii, who have shown increased interest in 1959 in this project.

The following letter dated March 14, 1960, was received from the American Medical Education Foundation:

On behalf of the Foundation Officers and Staff I would like to thank you for the fine job you have done for medical education during the 1959 fund effort.

A significant increase in the number of contributors as well as the amount contributed clearly reflects the fine work you have done on behalf of this very worthy cause. We sincerely hope you received the same satisfaction when reviewing these figures that we received each year when presenting the physicians' contributions for medical education to the 85 medical schools in the United States.

Thanks again for a job well done.

MIN HIN LI, M.D.

Report of the American Medical Education Foundation:

Your reference committee recommends approval and acceptance of the report and further recommends to the Council of the Hawaii Medical Association that it includes in its budget some money for the use of the AMEF in soliciting funds for publicity. The reference committee also wishes to commend Dr. Min Hin Li for his untiring work as chairman of this Committee.

ACTION:

The Chairman moved adoption of this portion of the report.

Dr. Berk asked if it were in order to thank the Woman's Auxiliary for the part they played in helping the AMEF this year. Dr. Sloan said they had been thanked for their work. Dr. Nishigaya pointed out that the recent fund-raising party was carried out at a county level.

DIABETES COMMITTEE

The 1959 Diabetes Drive was held during the week of November 15 to 21. The program selected by the Committee was similar to that conducted last year. The primary aim was to educate the public to be tested for diabetes. The public was advised to go to their own physician's office. This educational program was directed by means of radio spot announcements; radio discs; interviews on radio programs; TV films obtained from the ADA; press releases to the English, Japanese and Chinese newspapers; large posters distributed to the drug stores by the Woman's Auxiliary; and a window display at the Home Insurance Office on King Street.

To initiate the program for 1959, a few members met with Governor William Quinn for the signing of the "Message from the Governor" on behalf of the Diabetes Drive. A photograph was subsequently used in the paper to publicize this Diabetes Drive.

The Committee members felt that they would rather not participate in a TV live show in view of the availability of excellent TV films from the ADA.

The Committee discussed tentative plans for next year's program. Inasmuch as the present survey with the clinitron will be concluded, it may be possible, according to Dr. N. Sloan, to set up testing stations with the clinitron in various parts of town during the 1960 Diabetes Week. It was also recommended that reservations for show windows for the diabetes display be made a year in advance so that we can be assured of having a place for the display.

I would like to report that the members of this Committee were very cooperative and eager participants. For next year's chairman I would like to recommend Dr. Donald Brown.

In summary, the 1959 Diabetes Drive was conducted as a public education program. Facts on Diabetes were disseminated by the radio, TV, newspapers, window display, and posters. Governor Quinn initiated the drive with a special message. Next year we hope that a more direct approach of testing the public with the clinitron will be available.

COOLIDGE S. WAKAI, M.D.

Report of the Diabetes Committee:

Your reference committee recommends approval of this report and wishes to call the attention of the President to the suggestion for next year's chairman of this Committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII MEDICAL JOURNAL

The average issue of the JOURNAL in the fiscal year just ended contained 80 pages of advertisements (19 more than last year) and 18 pages of articles (2 more than last year).

The total size averaged 130 pages, as against 107 last year. The magazine is getting larger, and more prosperous.

The 29 articles published were written by 32 members of our Association and six guests. Material continues to be just sufficient for our needs, with the bottom of the manuscript barrel almost visible most of the time. In the first issue of Volume 19 a new feature, Infant Death Case Studies, was begun, and it is planned to continue it. Material is supplied by the Advisory Committee to the Bureau of Maternal and Child Health.

Dr. Hasegawa resigned as News Editor and his place has been taken by Dr. Kenneth Momeyer. No one has volunteered for the never-yet-occupied position of Assistant Editor. Dr. Momeyer is about ready to resign as we go to press.

Following is the usual five-year tabulation of size, income and expense. This year, for the first time, expense includes a prorated share of the salaries of the Managing Editor and her secretary; a breakdown of the major items appears below.

AVERAGE NUMBER OF PAGES PER ISSUE

	1955-56	1956-57	1957	1958	1959
Scientific	16	20	19	16	18
Features	25	33	23	22	24
Nurses	8	10	12	8	8
Advertisements	47	51	56	61	80
Total	96	114	110	107	130

TOTAL INCOME AND EXPENSE PER YEAR

	1955-56	1956-57	1957	1958	1959*
Income	$19,014	$21,127	$26,771	$27,829	$29,130.71
Expense	16,394	18,454	26,027	29,471	27,426.16
Net	$ 2,620	$ 2,673	$ 744	$(1,642)	$ 1,704.36

No Publications Committee has yet been formed to oversee the publication and finances of the JOURNAL and to rule on publishing and advertising policies.

An attempt (with the March-April issue) to print the magazine by offset lithography instead of letterpress resulted in a technically unsightly fiasco and seems unlikely to be repeated.

In summary, the JOURNAL is out of the financial doldrums of 1958 and doing well, and we recommend its continued publication, preferably under a standing Publications Committee.

HARRY L. ARNOLD, JR., M.D.

Report of the Hawaii Medical Journal:

Your reference committee respectfully calls your attention to the section of the report concerning the formation of a Publications Committee and it is recommended that such a committee be appointed in accordance with the action taken by last year's House of Delegates. We also note with satisfaction that the JOURNAL is self-sustaining financially and wishes to commend Dr. Harry L. Arnold. Jr., for his long and active career as Editor.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAIIAN ACADEMY OF SCIENCE

The Association gave support to the Academy of Science through the various members of both groups. The chief function, however, was the support given to the Annual Science Fair during which time members of the Association served as consultants and judges. The Association gave one prize to a senior exhibit and three prizes to the junior exhibit. There was general agreement among judges that the medical and biological exhibits were of high calibre. The Association has representatives at all Academy functions and one of its members, Dr. Fred Gilbert, served as president-elect of the Academy.

W. HAROLD CIVIN, M.D.

Report on the Hawaiian Academy of Science:

Your reference committee recommends approval of the report of the representative to the Hawaiian Academy of Science and also recommends continued financial support of this worthy project.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MABEL SMYTH BUILDING BOARD OF MANAGEMENT

Dr. Arnold Jr. and Dr. Liljestrand represented the Association on this board during 1959; Dr. Masato Hasegawa replaced Dr. Liljestrand in 1960, and Dr. Nishigaya became the new alternate. Mrs. Esther Stubblefield and Mrs. Mary Walsh represented the Nurses Association, and Mr. A. J. Hebert continued as representative of The Queen's Hospital.

Use of the building has been brisk this past year:

	TIMES USED	TOTAL ATTENDANCE
Auditorium	138	24,585
Committee meetings	290	3,684
Refreshments served	40	2,940
Total		31,209

The Building has lost a charter tenant: the Board for Licensing of Nurses has moved to rent-free quarters in the State Building. Part of their space has been taken up by the Medical Employment Service of the Honolulu County Medical Society.

Regular Sunday services have been held in the auditorium all year by the Harris Memorial Church, and this will continue for another year at least. We have also been able to rent the auditorium for several lecture series and have more in prospect.

Maintenance has not been neglected: the auditorium seats have been renewed, the men's room on the ground floor has been completed, and new lights have been installed in the lobby and on the lanai. The outside trim has been repainted and some painting done in the rest rooms and kitchen.

Total income for the last fiscal year was up $1,651 over the previous year, to $15,725; expenses were $12,346: net gain, $3,480. The Nurses and Physicians Exchange spent $28,350 to make $30,056, a profit of about $1,700.

Your representatives believe the building is being efficiently managed by Mrs. Storme, under our supervision. We would remind the Association that it has assumed responsibility for the building's maintenance; that it is, in essence, its own landlord and its own tenant.

HARRY L. ARNOLD, JR., M.D.

Report of the Mabel Smyth Building Board of Management:

Your reference committee recommends approval of the report and wishes to call to the attention of the doctors in Honolulu that the Physicians' Exchange is our best tenant. The utilization of the Exchange not only helps with the financial stability of the building, but also pays the salary of the management. Any suggestions or criticisms of the service should be directed to the building administration.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ASSOCIATION OF THE PROFESSIONS IN HAWAII STUDY COMMITTEE

This Committee had one meeting under the Chairmanship of Dr. Edwin K. Chung-Hoon, who was forced to resign because of ill health. At that meeting there was a general discussion on the need for such an association and whether or not there would be enough interest in it to make further study worthwhile.

The Committee did not reach any final conclusions and wishes to pursue the matter further before making any recommendations. The executive secretary from the state where this idea originated, Mr. William Burns, will be in Honolulu at the time of the 104th Annual Meeting and it is hoped he will be able to give us more detailed information on this plan at that time.

A. L. VASCONCELLOS, M.D.

* Five issues only.

Report of the Committee of the Association of Professions:

Your reference committee makes the following recommendation. It is felt that an Association of Professions in Hawaii is an excellent idea, but further study should be made as to its acceptance by the other professions. Therefore, it is the opinion of your reference committee that this Study Committee be continued and more information be presented to the Association at a future date.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSOCIATION

The Woman's Auxiliary to the Hawaii Medical Association has finished a busy year of diversified activity, during which it has (1) tried to promote the National Auxiliary's Priority Projects; (2) carried on additional local programs; (3) had one very profitable new experience; and (4) through all the above and other ways assisted the Hawaii Medical Association.

Mrs. Frank Gastineau, National President, requested all auxiliaries to emphasize this year *Community Service, American Medical Education Foundation,* and *Legislation.*

It is in the field of *Community Service* that the two small auxiliaries did an excellent job. Members on Kauai have worked for the hospital auxiliary, Blood Bank, Y.W.C.A., Brownies, Easter Seals, Red Cross, Girl Scouts, P.T.A., Cancer Board, Little Symphony Concert, the newly-organized theater group, the Rehabilitation Center, libraries, and the nurses' scholarship program. Maui members have given hundreds of hours of service to the Cancer Society, Children's Home, Community Chest, 4-H Club, Health Council, Historical Society, Missionary Society, Old Folks Home, P.T.A., Scouts, Tuberculosis Association, Philharmonic Society, and the Women's Club.

On Oahu too countless hours of *Community Service* have been contributed by individuals. In addition, as an Auxiliary, members have distributed 200 Diabetes Week posters, made 1,500 telephone calls for the National Polio Foundation Inoculation Survey, distributed leaflets promoting the H.M.A. television program on "Anemia," rendered assistance in the promotion of the Medical Forum, tabulated 8,000 survey sheets for the March of Dimes committee, and sent a delegation to the Governor's Conference on Aging.

To *A.M.E.F.* the Hawaii Auxiliary has contributed from 1956 through 1959 a total of $3,388.48. So far in 1960, $63.00 has been contributed, but it is hoped that a Honolulu County Auxiliary benefit to be held soon will clear $1,200 for this cause.

To emphasize *Legislation* pertinent to the medical profession, the Auxiliary has encouraged education of its members on HR 4700 (the Forand Bill) by newsletter, talks, and pamphlets. A resolution urging the three congressmen from Hawaii to vote against this bill was sent from the state Board of Directors; another was sent from the Honolulu County Auxiliary Board. Individual members were also encouraged to write to the same three congressmen about HR 4700. One Honolulu County meeting was turned over to a member of the State House of Representatives who talked on legislation which is vital to doctors here in Hawaii. Last, the Honolulu Auxiliary's legislative chairman attended the doctor's legislative committee meetings when her presence was requested.

In addition to the above activities, the Auxiliary has again helped with sponsoring the nation-wide essay contest on "The Advantages of Private Medical Care" and "The Advantages of the American Free Enterprise System." It has encouraged all doctor's wives to have annual physical examinations. It has sponsored a trip by members to see the Civil Defense facilities in Diamond Head. In making plans for the convention, it has, upon the request of the Hawaii Medical Association, made arrangements to help entertain wives of Mainland doctors attending the H.M.A. convention. The biographical file of doctors who have practiced in Hawaii, incorporated in what has now grown to three volumes of *In Memoriam,* has been kept up to date with the addition of accounts of the four doctors deceased this year and by the revision of two others. Members also have made approximately 500 telephone calls to help the H.M.A. with two projects.

One of the most progressive steps taken to increase the vitality of the Auxiliary was the sending of the President-elect to Chicago to the National Conference, the working and training session of the national organization. This was made possible by the combined generosity and cooperation of the National Auxiliary and the Hawaii Medical Association. Then, in turn, the State Auxiliary held a working conference last November, where education of members was emphasized for the first time.

The total membership as of March 31, 1960, was 261, with 13 from Kauai, 26 from Maui, 4 members-at-large on Hawaii, and 218 from Honolulu. However, by May 1, the total should rise to approximately 275.

Upon the advice of Dr. Toru Nishigaya, a special finance committee formulated a plan to improve the financial status of the state auxiliary. It is hoped that the House of Delegates will act favorably on this report in May.

Actually everything that has been reported has been an effort, directly or indirectly, to help the doctors' organization. The Hawaii Medical Association must always feel that its Auxiliary is ready to assist in any way it can, especially in the fields of public relations and entertainment.

The Auxiliary, in turn, is very grateful to its advisory committee—Drs. O. D. Pinkerton, H. Q. Pang, and Frederick Giles—and to President Toru Nishigaya, for giving their time and demonstrating an interest in the Auxiliary's welfare.

It has been a pleasure and a privilege to serve as president. Special commendation should go to Mrs. Robert Katsuki for her faithfulness over the years to the *In Memoriam* project and to Mrs. Douglas Bell, Mrs. Howard Liljestrand, Mrs. George Garis, and Mrs. Herbert Pang for outstanding service this year. The president, however, feels only admiration, respect, and gratitude toward every member who has willingly in any way given time, energy, and financial support to help make our Auxiliary a stronger and more effective group.

MRS. HOMER R. BENSON

Report of the Woman's Auxiliary to the Hawaii Medical Association:

Your reference committee recommends approval of the report and wishes to commend the President and her members for a job well done.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSOCIATION

This Committee met once informally and once formally with representatives of the Woman's Auxiliary, the latter being with the Special Finance Committee of the Auxiliary.

The Committee feels that the Woman's Auxiliary has ably continued its program of assistance to the medical profession not only in the field of public relations but in such programs as AMEF, and has been helpful in making a success of such projects as liaison meetings between members of the legislature and the physicians.

Presented as an addendum to this report are:

(1) A letter from the Special Finance Committee of the Woman's Auxiliary which is concise and self-explanatory and stated briefly is a request that five dollars be added to all physicians' State Medical dues and that this sum be utilized for the operating expenses of the State Auxiliary. This would automatically greatly strengthen the Auxiliary in numbers. Your Advisory Committee feels that this is good and will accomplish two objectives:

(a) Make the Auxiliary solvent and bring about an orderly budgetary program.

(b) Bring all the women of the profession into a strong, unified, and more effective body. The tax features inherent in this plan plus the simple fact that the physicians are already

paying their wives' dues, plus making up their present budget deficit, are important features to be considered.

(2) The proposed budget of the Auxiliary.

The House of Delegates has previously approved action to match funds up to $500.00 with those of the Woman's Auxiliary for the purpose of sending a delegate to the AMA Auxiliary Convention. The Auxiliary will be able to finish the year 1960 only by the utilization of money from an emergency fund not yet tapped.

The Advisory Committee respectfully requests and urges approval by the House of Delegates of the request outlined in Item 1.

O. D. PINKERTON, M.D.

Addendum to the Report of The Advisory Committee to the HMA.

The Woman's Auxiliary to the Hawaii Medical Association earnestly requests that five dollars be added to the doctors' state medical dues in order to incorporate in the Hawaii Medical Association's budget a provision for taking care of the operating expenses of the Woman's Auxiliary.

Keeping in mind the important tax deductible angle and the sharing of its Auxiliary's expense by the entire medical association, we feel this is the most practical and equitable means of obtaining the revenue for the auxiliary's maintenance. This will amount to approximately $2,500.00, of which $500.00 goes to National, leaving the State Auxiliary $2,000.00, adequate funds to function effectively.

We hope that the aid which we can give the Hawaii Medical Association, especially in the fields of community service and public relations, will continue to grow as it has during the last twelve years.

SPECIAL FINANCE COMMITTEE
(S) Mrs. Howard Liljestrand
(S) Mrs. Douglas Bell
(S) Mrs. Homer Benson

PROPOSED BUDGET FOR 1960-1962 FOR THE WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSN.

(Contingent upon raising approximately $2,500.00 for operations, which would mean $5.00 from each member of the Hawaii Medical Association.)

INCOME FROM DUES	$2,500.00
DUES TO NATIONAL AUXILIARY	500.00
	$2,000.00
COMMITTEE ALLOTMENTS	
In Memoriam	35.00
Hospitality	100.00
Membership	5.00
Legislation	5.00
Essay	5.00
Publicity	5.00
A.M.E.F.	5.00
Others—Bulletin, Mental Health, Safety, Finance	50.00
SUPPLIES (Printing, etc.)	50.00
PRESIDENT'S DISCRETIONARY FUND	
Hospitality	25.00
Telephone	5.00
Postage	125.00
Travel	75.00
PRESIDENT-ELECT'S FUND, DELEGATE TO NATIONAL CONEERENCE	500.00
SECRETARY	10.00
TREASURER	10.00
CONTINGENCY FUND	100.00
STATE BENEVOLENT FUND	400.00
STATE CONEERENCE	
Local arrangements and travel for neighbor island president and president-elect	250.00
CONVENTION—Local arrangements	100.00
A.M.E.F.	100.00
	$1,960.00

Report of the Advisory Committee to the Woman's Auxiliary to the Hawaii Medical Association and the Addendum by the Special Finance Committee:

Your reference committee. after much discussion, and after a special presentation by the Finance Committee, recommends approval of both reports and further recommends that the Council of the Hawaii Medical Association raise the dues $5 a year in order to finance the expenditures of the Woman's Auxiliary. It was pointed out that the tax features in this plan make it more desirable to sustain our Auxiliary in this manner and give the members a working capital and a sound membership. It is further pointed out that many states use the same method of collecting money for this purpose.

ACTION:

Mr. Kennedy said he didn't think this conformed with the bylaws. The chair did not concur.

This portion of the report was adopted.

PHYSICIANS AID STUDY COMMITTEE

Two meetings were held, the first in September, 1959, and the second in March, 1960. The first meeting was explanatory and involved discussions and personal opinions of various members of the Committee, as well as other members of the Hawaii Medical Association. The second meeting, held on March 21, 1960, crystalized the opinions of various members of the Committee and after studying the problems and solutions of other state medical associations throughout the country, it was decided that the Committee would recommend to the delegates of the Hawaii Medical Association the acceptance of the report by their previous chairman, Doctor Verne C. Waite. The Committee thoroughly discussed and developed the problem and the recommendations have stood up under the test and examination of our Committee.

We felt that in view of some of the difference in opinion, that it might be well for the members to have the privilege of voting on this problem. Many voted to add Section D to the recommendations of Doctor Waite as follows:

> Repayment. The Committee realizes at times that recovery from financial strain may be accomplished, and in those cases where the individuals are financially able, repayment to the fund is requested.

It was also recommended that Section A of Doctor Waite's report have an additional sentence added to read:

> Each new member subsequently gaining membership in the HMA will be assessed $10 a year each year for five years and this assessment may not start later than five years after admission to membership.

The Committee voted unanimously to accept Doctor Waite's report with the two changes as noted above.

F. L. GILES, M.D.

Report of the Physicians Aid Study Committee:

Your reference committee after considerable discussion recommends the following:

That the Hawaii Medical Association bill each member and indicate on the bill that a voluntary assessment of $10 a year be paid. This will indicate the interest of the members in this worthy project and give the Council an indication for further action.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION No. 2
Re: TRAINING IN OBSTETRICS AND SURGERY FOR GENERAL PRACTITIONERS

(Submitted by R. VARIAN SLOAN, M.D.)

WHEREAS, Medical educators have for years decreed the type and scope of in-hospital training afforded general practitioners, and

WHEREAS, This in-hospital training has often ignored the needs of the young general practitioner and his patient, and

WHEREAS, The recent action of the AMA House of Delegates in June of 1959 which recommends a prescribed two-year training program for future general practitioners which eliminates virtually all obstetrical training and all but the most minor of office surgery is a continuation of this same shortsighted policy; therefore be it

Resolved, That the Hawaii Medical Association instruct its Delegate to the AMA to support a change in the require-

ments for the new two-year family practice program to make training in obstetrics and surgery mandatory.

Resolution #2:

Your reference committee recommends approval of this resolution.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION No. 3
Re: 105th ANNUAL MEETING

(Submitted by RAYMOND C. YAP, M.D.)

WHEREAS, It is incumbent upon the Council to select the dates for the following year's annual meeting, and

WHEREAS, The Council has reviewed the several possibilities for 1961, and has seen fit to select May 4 through 7, 1961, as the dates for the 105th Annual Meeting of the Hawaii Medical Association; therefore be it

Resolved, That these dates be set by the House of Delegates this 13th day of May, 1960; and be it further

Resolved, That the Council be granted permission to change the dates set if they are found to cause a conflict which would not work to the best interests of the Hawaii Medical Association.

Resolution #3:

Your reference committee recommends approval of this resolution.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION No. 4
Re: LEGISLATION

(Submitted by Theodore Tomita, M.D. and Richard E. Ando, M.D.)

WHEREAS, the Legislative Committee of the Hawaii Medical Association has been effectively promoting sound medical legislation for the welfare of the people of Hawaii, and

WHEREAS, the tempo of legislation affecting medicine and public health has reached a crescendo of progressive government encroachment into the traditional freedom of the individual, and

WHEREAS, the effectiveness of the Hawaii Medical Association to encourage sound medical legislation can continue to come only from a thorough knowledge of the community's economic and sociologic factors; be it therefore

Resolved, that the President of the Hawaii Medical Association appoint a Research and Reference Committee of five or more members, to actively investigate prior to legislative sessions, the sociological and economic factors of pending State legislation regarding public health, medical practice and Government Medical Insurance plans; and be it further

Resolved, that the Committee report to the Hawaii Medical Association and the Legislative Committee of this Association at the earliest possible date, their findings to help promote more effective legislation to protect the needs of all the people of the State of Hawaii.

Resolution #4:

Your reference committee recommends approval of this resolution.

ACTION:

The Chairman moved adoption of this portion of the report.

Dr. Mills asked why the reference committee felt the present Legislative Committee could not do this job. Dr. Ando said that Dr. Tomita asked him to present this resolution because members of the Legislative Committee are very close to the legislators personally and have been able to get things done for themselves or the Association but they haven't had the time to get economic data. They are more or less limited and haven't time to get the details. They need to know the social and economic facts rather than to call on good friends in the Legislature. He felt that it would be beneficial to have good research and resource people. It is another way of asking aid practically gratis.

Dr. Millard asked what the Legislative Committee thought of it. It was noted that they had not been advised of this but the President in his discussions would point out the importance of this plan.

Dr. Cushnie asked if the resolution meant to get doctors or someone outside the Association. Dr. Ando said there wasn't much point in appointing a committee that doesn't have time to go into the matter. It would take an outsider to do this work.

Dr. Nishigaya said Dr. Tomita thought we could pay $10,000 to hire a sociologist or economist to do this work but we don't have the money. Dr. Ando said that with the facts the committee gathered the members of the Legislative Committee could talk a little more freely. Dr. Lambert thought it was an excellent idea and it should be an active committee and by next year we will know how effective it is.

This portion of the report was adopted.

Mr. Chairman, in conclusion the chairman of this reference committee on Miscellaneous Business wishes to thank the members of the committee for their help in the preparation of this report and our reference committee also wishes to extend thanks to those members who appeared before us to help us in our deliberations.

The Chairman moved adoption of the report as a whole. It was adopted.

Dr. Pang said that Mr. Kennedy had called his attention to the fact that there had to be a change in the bylaws to raise the dues. Dr. Sloan said that this was a matter for the council to handle.

Dr. Ivar J. Larsen was asked to make the final reference committee report.

REFERENCE COMMITTEE ON INSURANCE AND MEDICAL SERVICES

Mr. President and members of the House of Delegates:

Your reference committee on Insurance and Medical Service gave careful consideration to the matters referred to it and it makes the following report:

CANCER COMMITTEE

This Committee has not met since the last meeting of the House of Delegates. The Association's cancer activities were limited to establishing a central cancer registry and the task of doing this was the responsibility of the Cancer Commission.

GROVER H. BATTEN, M.D.

Report of the Cancer Committee:

Your reference committee received a verbal report from the Chairman of the Cancer Commission (Resolution #8, 1959 Session) relative to the activities of this committee during the past year. Numerous meetings of the committee have been held in organizing the cancer registry.

Your reference committee recommends that Resolution #8, 1959 Session, relative to the establishment of a Cancer Commission, be re-considered and suggests that possibly the Cancer Commission be a function of the Cancer Committee, responsible to the Committee, but the members of the Commission, not necessarily be members of the Cancer Committee. Your reference committee also recommends that a report of the Cancer Commission be incorporated in the annual report of the Cancer Committee.

Your reference committee also feels that the modus operandi be more clearly delineated and include tenure of office, activities, etc., of the present commission.

ACTION:

The Chairman moved adoption of this portion of the report.

Dr. Batten asked if it were the sense of this proposal that during the coming year, if this is adopted, that the Cancer Commission will be responsible to

the Cancer Committee which Committee is in turn responsible to the President. Dr. Larsen said that was the feeling. Dr. Waite said that from a practical standpoint, he thought the Commission should be set up as a sub-committee of the Cancer Committee because its one purpose is the Cancer Registry. Dr. Batten said the only reason for setting it up this way was to meet a deadline. It was a matter of applying for funds. If this is adopted, it shouldn't change the present make-up of the Commission. As presently set up it is not completely appointed by the President. He recommended the removal of the word "possibly." Last year the plan of operation was not clearly outlined.

Dr. Larsen amended his report to eliminate the word "possibly." This portion of the report as amended was adopted.

COMMITTEE ON CHRONIC ILLNESS AND AGING

This Committee held nine meetings during the year, with an average attendance of seven members. Two were joint meetings: one with the Federal Medical Services Committee to meet Mr. George Cooley, Secretary to the AMA Council on Medical Services; the other with the Health Division of the Program Committee for the Hawaii Conference on Aging (scheduled for May 6-7) and to meet Mr. Donald Sutcliffe, Regional Representative for the White House Conference on Aging. Guests at three other sessions were (1) Drs. Leon Lewis, Director of Rehabilitation Center, Fairmont Hospital, San Leandro, California; Charles Hayman, Consultant, Special Health Services, U. S. P. H. S., Region IX; and David Frost, Medical Consultant, Office of Vocational Rehabilitation, Region IX (here for the Governor's Rehabilitation Institute); (2) Miss Mary Noonan and Mr. Morris Fox of the Department of Social Services; and (3) Messrs. Oscar Fulford and Charles Aston of Hawaii Pacific Homes.

We have worked with the Governor's Commission on Aging in planning for the State and White House Conference on Aging. We supported the Rehabilitation Institute, and are glad to note the large number of physicians who participated in it, and the resultant benefit.

We recommended that the Hawaii Medical Association officially oppose the Forand Bill.

We supported continued separation of State Health and Welfare Departments (since approved by the Legislature).

Much time was given to discussion of financing medical care for the elderly. A suggestion for a plan to defer a part of medical charges until after death (charged to the estate) was deferred for legal advice and further discussion.

We approved distributing the brochure, "A Better Future for the Aged," to operators of nursing homes.

We endorsed the suggestion that Hawaii Pacific Homes include in their plans a nursing home for chronically ill, financially independent elderly patients.

Steeply rising hospital rates are a matter of great concern. We recommend that the hospitals study the "Manchester plan" of dividing facilities according to the degree of service required by patients, and charging accordingly.

The Committee recommends that a State Commission on Chronic Illness and Aging be set up and that the Hawaii Medical Association support whatever legislation is proposed.

Due to the absence of Dr. Beck, this report was compiled by Dr. Norman R. Sloan, with the approval of the vice-chairman, Dr. Shoyei Yamauchi.

L. CLAGETT BECK, M.D.

Report of the Committee on Chronic Illness and Aging:

Your reference committee recommends acceptance of this report with the following exceptions:

1. Deletion of Paragraph 5, which reads:

   "Much time was given to discussion of financing medical care for the elderly. A suggestion for a plan to defer a part of medical charges until after death (charged to the estate) was deferred for legal advice and further discussion. The committee felt it should be deleted "because of legal complication, poor public relations, and administrative difficulties."

2. In Paragraph 9, delete: "and that the Hawaii Medical Association support what ever legislation is proposed."

Your reference committee also recommends that the Committee on Chronic Illness and Aging meet with the State Association of Hospital Administrators to attempt to implement the suggestions in Paragraph 8, with regard to studying of the "Manchester plan."

ACTION:

The Chairman moved adoption of this portion of the report.

Dr. Larsen explained that the legal counsel of the Honolulu County Medical Society advised strongly against the proposal relating to collecting from an estate. Dr. Nishigaya asked Dr. Yamauchi if he had any comments to make. He had none. Dr. Nishigaya said that we are at another impasse. All the material is gotten together. We are trying to get something concrete. He thought the members should submit any ideas they have as far as this problem is concerned because if we do not get some answer to this, the government will sove it for us. We hope to anticipate that by presenting something concrete from the standpoint of the physicians.

What can we do to alleviate part of this problem? He mentioned Punchbowl homes. The Committee thought the Blue Shield program might make a pilot study there but the insurance people felt that would be too costly. The Committee will accept any ideas any one has on any phase of this problem.

With reference to the Manchester Plan, one of the things that came out of the Governor's conference on Aging was an attempt to utilize the idea of this concept of taking away the patients from the general hospital for the chronically ill and putting them where they can be taken care of at much less cost. Dr. Yamauchi said that out of the Governor's Conference a State Commission on Aging will be created, and as far as is practical, the area in which the doctors will be concerned will be chronic illness and its various aspects.

Past President Robert B. Faus said it was important that the Association definitely take a stand as to whether they will accept a portion amount of the relative value schedule for those over 65 that are medically indigent and indigent and that is the thing that is going to be requested. He thought we would eventually be asked to and we should not let it go until after the legislature makes a decision for us. He questioned whether we should follow Iowa's plan of taking 60% for the medically indigent and 40% for the welfare department patients.

Dr. Nishigaya apologized for taking the liberty of asking people to speak who are not members of the House of Delegates. This portion of the report was adopted.

EMERGENCY MEDICAL SERVICE COMMITTEE

The Emergency Medical Service Committee met on the first Monday of each month, at the Mabel Smyth Building. The highlights of the year were:

(1) Completion of assignments for: a. Physicians, b. Dentists, c. Nurses, and d. Medical Technicians;

(2) formation of a sub-committee for study of emergency medical communications;

(3) activation of aid stations; and

(4) activation requests for hospital "dry runs."

This committee, while discussing and formulating plans, had completed meanwhile the assignments of physicians, nurses, dentists, and medical technicians to go into effect in time of disaster. Everyone assigned was given a CD identification card with his assignment and instructions. Schools were designated as aid stations and the key personnel assigned to them. To facilitate the manning of CD hospitals, each major hospital was given an over-supply of key personnel who were made responsible for manning the CD units. The assignments were given not only on the basis of closeness of hospital and aid station to the person's

residence but the person's preference and specialty were taken into consideration. The committee felt that during disaster the weakest link in our organization is the problem of communications, therefore the Chair requested a sub-committee to study this problem under the chair of Dr. Peyton, who is the vice-chairman of this committee and who is also a licensed radio "ham." This sub-committee's report and suggestions are appended.

As soon as the aid stations were selected, the Mayor's office, upon our request, activated a cadre unit and began dry runs and unit training programs under Dr. Hiroshige. A member of this committee was made responsible for aid station and ambulance service. The demonstration was highly successful and the unit is now actively training the cadre groups of the 31 assigned aid stations.

Since this is an advisory group, the Committee can only request and advise. The various hospitals were requested by letter to activate a dry run. Several months have passed and the only response to date has been from the Queen's Hospital, they promised to try a test series after the new building program is completed. Cooperation is obviously poor compared with that of the aid stations. We have no high authority to turn to with the hospitals, as we had in the Mayor's office for the aid stations.

Personally, I feel that we medical men have been guilty of indifference more than the paramedics and are failing to provide the desired leadership. This can be seen in the excuses given by physicians assigned to the aid stations (see addendum). The public is justified in expecting good medical leadership in time of disaster. Our own families may need the aid of well organized medical units. This is our responsibility to our community and since human lives are involved the problem is not a small matter. Based on reports of activities on the national scale, this society of the medical profession cannot ignore the national demand for organization and activation.

In accordance with the motion carried at the last committee meeting it recommended that the initial base unit for the emergency communications system be placed in the Mabel Smyth Building.

This Committee, therefore, suggests that the new administration concentrate on educating our own group to its responsibility. The Chair feels, as do some members of the Committee, that after all these years of planning and work, because of a sense of failure on our part to provide the necessary leadership, "new blood" should be given the chance to provide this leadership.

ISAAC KAWASAKI, M.D.

Report of the Emergency Medical Service Committee:

Your reference committee endorses the recommendations of the committee concerning the defense activities and urges the membership of the Association to cooperate with the Committee and become more active in its support. Your reference committee also suggests that for the permanent record, the addendum to the Emergency Medical Service Committee's report be deleted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FEDERAL MEDICAL SERVICES COMMITTEE

During the past year, negotiations have been conducted by mail with the Office of Dependents' Medical Care Program in Washington, D. C. Several changes were requested over which we were unable to get together by mail. Accordingly, the previous year's fee schedule contract was then accepted, which was the wish of the people in the Washington Medicare Office, with the understanding that representatives from the Washington Office would be here. These representatives, Colonel Norman E. Peatfield, Professional Director, and Lt. Colonel Ernest G. Rivas, Executive Officer, met with representatives of the Society on April 5, 1960, at the Mabel Smyth Building and various facets concerning the Medicare Program were discussed. Colonel Peatfield made it quite clear that they are responsible to the General Accounting Office, which has a good and clear understanding of the going rates in each community, and it is very unlikely that we will have any change upward in rates until the local Blue Shield plan is actually paying more. In effect, our bargaining for relative value fee schedule rates means nothing at all to them until the Hawaii Medical Service Association is paying relative value fee schedule rates. On top of that, he says that the General Accounting Office and Medicare look askance at paying more when our family income ceiling is $9,000. He points out that the highest in other states is $7,200 and they can hardly see where they should pay even as much when the service man's average family income level is considerably below this. These two statements are the crux of the whole matter which is repeatedly facing your various committees in this community. The first step, to get our relative value fee schedule the general going rate on Hawaii Medical Service Association, is mandatory. Until then, we are going to get nowhere.

Incidentally, the going rate for an appendectomy paid by the Blue Shield in California is $175. Accordingly, Medicare has no hestitation in paying $160 for an appendectomy for Medicare patients in California.

After discussion about the six weeks cut off period for postpartum care, Colonel Peatfield said that it does not matter when a usual postpartum visit takes place even if it is after 42 days provided that there are no other charges. However, they will not be responsible for any complications in the postpartum period that begin after the 42d postpartum day. This matter is being clarified with our local fiscal agent by him.

Considerable discussion was held with Colonels Peatfield and Rivas about relations between the State Committee and the Review Board in Washington. We believe that we understand each other quite well now and that many differences of opinion were largely matters of communication, the mechanics of which are now clear.

The Veterans' contract for the coming year was renewed inasmuch as there was no objection from any county with the present contract. Since we have become a state, some of those previously eligible for Dependents' Medical Care in the counties of Hawaii, Maui, and Kauai have become ineligible; but there is a bill introduced by Congressman Inouye which may, if passed, correct this situation. This bill, it is my understanding, is well supported by veterans' organization.

It is apparently the wish of the various county societies after considerable discussion and trips to Washington on the part of the Honolulu County Society that the Hawaii Medical Service Association qualify under Section 4 (4-B) in the new law which gives financial aid to civil service workers. Time only will tell whether or not this is wise. It is probably a situation of "we're damned if we do and we're damned if we don't" and the doctors are caught in the middle. All societies, I believe, have been fairly apprised in this matter by our President and his associates and at the meeting held in Honolulu by the Honolulu County Medical Society to which I invited representatives from all of the Neighbor Islands.

I would like to recommend to the incoming president that he continue the policy of staggering appointments to the Federal Medical Services Committee so that approximately one-third old members go off and one-third new members come on in any one year. The retention of a certain number of old hands who know the ropes and the previous policy decisions is essential. It is also, I believe, wise to continue the policy of having the appointments made up of a wide spread of interests within our medical society representing general practice and the various specialties. This affords a wide spread of knowledge in the practice of medicine and has been of considerable aid in solving our various problems. Inasmuch as obstetrics and pediatric care are high, percentage-wise, in usage, I believe that these two fields should be represented on the committee.

In closing, I would like to thank all the various members of the committee, particularly those from the neighbor Islands who left their practice and spent nights away from home, for their sincere and helpful interest throughout the past year.

C. C. MCCORRISTON, M.D.

Report of the Federal Medical Services Committee:

Your reference committee recommends acceptance of same, with thanks.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MENTAL HEALTH COMMITTEE

In meetings of your Mental Health Committee during the past year, a number of important subjects were discussed. The proposal of the Western Interstate Commission for Higher Education to establish short-term training for nonpsychiatric training physicians in our community by means of intensive 10-week seminars for small groups was given strong support and referred to the Honolulu County Medical Society for action, with our favorable recommendation. A subsequent report from Dr. Warren T. Vaughan, Jr., the Director of Mental Health Training of WICHE, indicates that Hawaii will participate in the second round of courses next year.

In respect to State governmental reorganization activities, our committee went on record supporting a separate Department of Health, including in it a Division of Mental Health with closely integrated services. The committee recommended that the Territorial Hospital and Waimano Home be included within the Division of Mental Health. In this way research activities, community education, and inpatient and outpatient psychiatric services would be closely coordinated.

The Mental Health Committee also recommended that the Hawaii Medical Association accept the invitation of the Mental Health Association to co-sponsor a workshop on marriage to be held in June of this year. The chairman of the Mental Health Committee has been appointed to the Planning Committee of this workshop.

KENNETH H. RUSCH, M.D.

Report of the Mental Health Committee:

Your reference committee recommends acceptance of this report as corrected verbally by its chairman, wherein the last paragraph reads:

"The Mental Health Committee also recommended to the President of the Hawaii Medical Association that the Hawaii Medical Association accept the invitation of the Mental Health Association to co-sponsor a workshop on marriage, to be held in June of this year. This recommendation has been favorably acted upon by the President of the Hawaii Medical Association."

With reference to Paragraph 2, your reference committee suggests that it be recorded that the Division of Mental Retardation has been separated administratively from the Division of Mental Health.

ACTION:

The Chairman moved adoption of this portion of the report.

Dr. Larsen explained that the reference committee was concerned about what the definition of a "work-shop on marriage" might be. There was considerable speculation among the committee members and so they asked the chairman to clarify it.

Dr. Berk said that in the Health Department program there has been a split in the division of mental health. There will be a separate division for the Department of Mental Retardation. This division will be submitted to the Legislature. Dr. Bernstein said that the division is already a fact.

This portion of the report was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF WORKMEN'S COMPENSATION

This Committee has not been called up to attend any meetings or to assist with any Workmen's Compensation problems since the last meeting of the House of Delegates.

Honolulu County Medical Society has taken the responsibility of negotiating a new fee schedule for the State of Hawaii. Their reports are not directed to this Committee.

RALPH M. BEDDOW, M.D.

Report of the Advisory Committee to the Bureau of Workmen's Compensation:

Your reference committee recommends acceptance of the Committee's report. Your reference committee also suggests that Hawaii Medical Association accept the fee schedule negotiated by the Fee Schedule Committee of the Honolulu County Medical Society as a state-wide Workmen's Compensation Fee Schedule.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION No. 1
Re: VETERANS ADMINISTRATION AND CARE OF PATIENTS WITH NON-SERVICE CONNECTED DISABILITIES

(Submitted by F. J. PINKERTON, M.D.)

WHEREAS, The members of this Association are in full agreement with the vast majority of the American people that the federal government should provide the best possible medical and hospital care for veterans with service connected disabilities, and

WHEREAS, The present Veterans Administration policy permits medical treatment of veterans with non-service connected disabilities by the Veterans Administration, and

WHEREAS, According to the figures of the House Veterans Affairs Committee submitted to the American Medical Association, total number of patients in Veterans Administration hospitals on January 12, 1959 was 113,819 of which 67 per cent (76,259) were hospitalized for non-service connected disabilities costing the American taxpayer more than one billion dollars annually, and

WHEREAS, According to the same source, as of February, 1960, there were 22½ million veterans in civilian life, and

WHEREAS, The emergency of the cold war with Communism is and will be responsible for forcing most of the male population into the veterans classification, all of whom will be eligible for free medical care at federal government expense through existing Veterans Administration policy, and

WHEREAS, Continuation and extension of such undeserved care for veterans with non-service connected disabilities places a growing additional tax drain on an already greatly overtaxed populace, and

WHEREAS, Continuation of the present Veterans Administration policy of providing special privileged medical care for veterans with non-service connected disabilities will lead to demands from other groups for special privileged medical care for their respective groups, and increase greatly the expenses of an already too expensive federal government to the further disadvantage of the tax-payers; therefore, be it

Resolved that we, the Delegates of the Hawaii Medical Association in regular session assembled this 13th day of May, 1960, make the following recommendation to the President and the Congress of the United States: That the Veterans Administration Act be amended to prove medical and hospital care to veterans for service connected disabilities only; and be it further

Resolved that a copy of this resolution be spread upon the Minutes of this Meeting and that copies of it be sent to (1) the President, (2) all members of Congress, and (3) all state and county medical societies.

Resolution No. 1:

Re: Veterans Administration and Care of Patients with Non-service Connected Disabilities.

Your reference committee recommends adoption of this resolution with the following changes: Paragraph 5 to be deleted and the following paragraph be substituted—

"WHEREAS, Because of present Draft Law, a large percentage of the male population will be forced into veterans' classification, all of whom will be eligible for free medical care at Federal government expense through existing Veterans Administration."

Paragraph 8, 42d word "prove" (medical and hospital care . . .) should be changed to "provide" (medical and hospital care . . .).

Your reference committee also suggests that the Hawaii

Medical Association delegate to the American Medical Association be instructed to present a similar resolution for adoption by the American Medical Association.

The Chairman moved adoption of this portion of the report. It was adopted.

The Chairman moved adoption of the report as a whole as amended. It was adopted.

Dr. Nishigaya complimented the Delegates on their work. He commended the reference committee chairmen for their efforts in reviewing the reports prior to the convening of the House. He said he was very proud to be associated with members who have taken such a great interest in the affairs of the Association not only for themselves but for the other members of the Association.

Dr. Nishigaya read the Nominating Committee's report.

NOMINATING COMMITTEE

The Nominating Committee met at 4:15 P.M. in Honolulu on April 12, 1960, to select nominees for the office of President-elect, Secretary, and Council. The Committee paid special attention to the office of President-elect and followed the policy of nominating to that office a member who was willing to serve and who possessed some knowledge of the administration of the Association by virtue of his past offices and committee assignments. Further, the Committee followed tradition and searched for its candidate from the rolls of the Maui County Medical Society. After consulting with the officials of the Maui County Medical Society and after due consideration by the Committee the name of J. Alfred Burden, M.D., is offered in nomination to the office of President-elect.

The official slate of nominees is therefore submitted as follows:

PRESIDENT-ELECT.....J. Alfred Burden, M.D.
SECRETARY.....Rodney T. West, M.D.

TWO COUNCILORS from Honolulu County Medical Society
Homer R. Benson, M.D., Randal A. Nishijima, M.D.

ONE COUNCILOR from Maui County Medical Society
(to complete Dr. Burden's unexpired term)
James F. Fleming, M.D.

All nominees have accepted the nomination except Doctors Fleming and West, who are in Europe at present.

E. K. CHUNG-HOON, M.D.

There being no nominations from the floor, the Secretary was instructed to cast a unanimous ballot for those men who had been nominated and the foregoing new officers were elected.

Dr. Berk moved that this House of Delegates go on record as thanking its President for the work he had done. He said he knew for one that he had been present at more meetings than any one knew about; that we know that he has been working for the welfare of the Association; that he be thanked and the appreciation be voiced vocally. [applause].

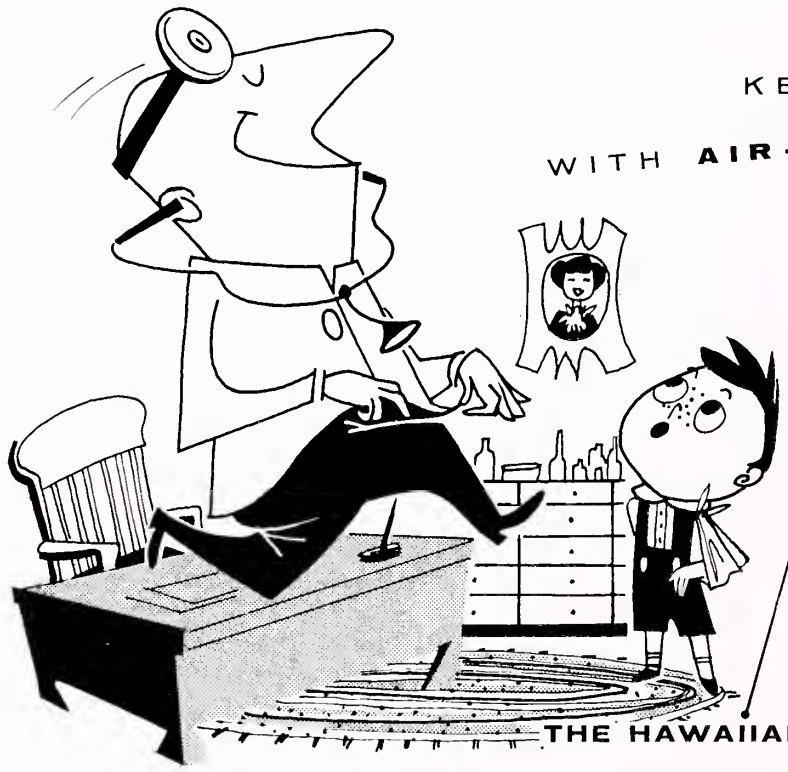
The motion was seconded and passed.

Dr. Berk moved further that the President and the officers who were instrumental in setting up the committees and the organization of business the committees went over have a vote of thanks to the executive secretary who set up the work and helped and all the other help she has done for the past year.

Dr. Leong asked if we had accepted Dr. Faus's question and the President advised it was not pertinent to the business of the House of Delegates.

The meeting adjourned at 2:50 P.M.

RAYMOND C. YAP, M.D.
Secretary



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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, State of Hawaii

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Nursing Education and Nursing Service

Note from the Editor

This issue is dedicated to the students of Hawaii's Schools of Nursing. The following articles have been submitted by student nurses and by nursing leaders in the community.

NSNA Meeting in Miami

Words cannot describe the excitement and anxiety I felt during the National Student Nurses' Association Convention held on April 28 to May 2, 1960, in Miami Beach, Florida. This was my first trip anywhere! I was fortunate to travel with Sister Maureen, Administrator of St. Francis Hospital. On the way to Florida, we detoured to New York City. This fabulous city has so much to offer. I saw Central and Penn Stations, Central Park, Times Square, the Empire State Building, the United Nations Building, and Rockefeller Center. In Florida, I attended the business meetings of the National Student Nurses' Association. There were meetings for presidents of the State Nurses' Association with the former National President, Mary Kuntz. During these meetings we all brought out our problems and asked each other for suggestions or solutions to them. But it was not all work because there were enjoyable programs going on during the evening hours. There was a poolside party at the di Lido Hotel and a talent show held in Convention Hall. I also tried to grab some sun and swimming in the hotel pool. Then last, but not least, I took a boat tour to Parrot Paradise and saw a Seminole Indian wrestle an alligator.

When the time came for me to come home I had misgivings. I wished I could stay longer to get a better view of this beautiful country of ours. I hope that someday we may be able to send more delegates to this convention to gain the rich experiences I have gained. May I take this opportunity to thank the St. Francis Hospital Auxilliary, the St. Francis School of Nursing Alumnae, my student body, the Hawaii League of Nursing, the Hawaii Nurses' Association, and the Hawaii Student Nurses' Association for making this trip possible. But most of all I thank Sister Maureen for her hard work to get me to Florida, and Mrs. Mary Walsh for making my trip possible by collecting Super Saving Stamps.

MARJORIE ODA

HSNA Workshop

The Hawaii Student Nurses' Association held a Workshop on May 21, 1960, from 9:00 A.M. to 2:30 P.M. at the Mabel Smyth Auditorium to train each other to gain new knowledge, skills, or insights into problems of the association. The Workshop attracted some 66 students from the three nursing schools—Queen's, St. Francis, and the University of Hawaii.

Miss Mildred Maeda, new HSNA president, presented the welcoming speech and also introduced the new officers. A report of the NSNA convention at Miami, Florida, was made by Miss Marjorie Oda, outgoing president of HSNA, who was the Hawaiian delegate. The audience participated by dividing into small discussion groups on problems of communication, relationship, etc. Several new suggestions for future HSNA programs were offered. Evaluation of the Workshop made by those attending showed that they all enjoyed the Workshop and were interested in having one each year.

PAULINE MAHEULA

NLN Consultant Helps with Nurse Recruitment

Statehood brings privileges as well as responsibilities. One of the former was our inclusion, for the first time, in free consultant service on nurse recruitment from the National League for Nursing.

Mrs. Irene Miller, Field Consultant on Careers in Nursing, was with us for the week of April 4, 1960. Her activities during the week included talks at a joint meeting of HNA and HLN, con-

ferences with all schools of nursing, a luncheon meeting with representatives of the Medical Auxiliary and the Hospital Association, a League-sponsored dinner, and one day and night on Kauai as guest of the Kauai Nurses Association Scholarship Committee.

The climax of the week was the Future Nurses Club Workshop held in the Mabel Smyth Building on Saturday, April 9.

Through the generosity of Frear Eleemosynary Trust, Juliette M. Atherton Trust, McInerny Foundation, Samuel N. and Mary Castle Foundation, and the Hawaii League for Nursing, we were able to pay the plane fares of the faculty representatives from the neighbor islands and of one student from each active Future Nurses Club. Box lunches were served free at noon to all participants of the workshop.

Mrs. Miller was the keynote speaker. She also met in discussion with all club advisors. High school students met in small groups to discuss organization of clubs and what makes a good club "tick." Students from our four schools of nursing acted as group leaders. Professional nurses from the nursing schools and hospitals served as resource people.

Under Mrs. Miller's expert guidance as moderator for the panel of high school student reporters, many interesting and thought-provoking ideas and problems were presented with spontaneous discussion involving the audience as well as panel members.

A total of 180 people participated in the workshop. Eleven neighbor island high schools and 13 high schools from Oahu were represented.

The chief aim of the workshop was to stimulate the organization of more active Future Nurses Clubs in high schools all over the state with scholastic standards for membership. It is through membership in these well organized clubs that high school girls can become aware of the many opportunities which nursing has to offer and they can be helped toward a realistic evaluation of their own nursing interests.

The Careers Committee of HLN provides handbooks and other literature on club organization but there is a great need for more personal contact and assistance from professional nurses on a local basis to keep these clubs functioning on a high level.

This kind of consultation service from NLN is very timely since Hawaii's hospital schools of nursing and the Practical Nursing School are finding it difficult to recruit a sufficient number of well qualified applicants.

We are very proud to quote from Mrs. Miller's recent letter:

"As I told you in a personal note earlier, I honestly believe it was the best workshop of its kind that I have ever attended. I believe it is nothing less than remarkable that your SLN could manage it so successfully when it was the first project of this kind that you had ever undertaken."

MARJORIE ELLIOTT

Birth and Development

The Hawaii Student Nurses' Association or "HSNA" was created in 1949 when the nursing students of Kuakini Hospital School of Nursing, Queen's Hospital School of Nursing, and St. Francis Hospital School of Nursing voted to organize and adopt a Constitution and Bylaws. The idea of an over-all students' organization was first discussed by students who attended the annual meeting of the Nurses' Association in 1948.

In the early years, the HSNA, through meetings of its executive council, planned projects in which all students would participate. An annual dance was the source of funds for a scholarship program to help three students in need of financial help to continue their nursing education. Very early in its development HSNA joined forces with the Nurses' Association Committee on Recruitment to Nursing and nursing students took an active part in the program to reach high school students. HSNA members met once a year at the HSNA Annual Meeting which was usually held during the annual meeting of the Nurses' Association.

Hawaii is one of twelve state student nurses' association which antedated the creation (in 1953) of the National Student Nurses' Association. This National Association got under way in 1952 when 1,000 students present at the American Nurses' Association Convention in Atlantic City voted to form a national organization, elected temporary officers and drafted a constitution and bylaws. Today, NSNA is a federation of constituent associations in 49 states and the District of Columbia, and in addition it has over 200 district or local associations. NSNA is an independent organization sponsored by the coordinating council of the American Nurses' Association and the National League for Nursing. Today over 80,000 nursing students (70%+) of eligible students, are members. In fact, this is the largest single organization of professional students of any kind in the United States.

NSNA has a full-time paid executive secretary and two assistants, and an office at 10 Columbus Circle, New York City. NSNA publishes a quarterly newsletter to keep members abreast of international, national, and state activities in nursing; sends representatives to committees of ANA and NLN and to such national meetings as the 13th

National Conference on Citizenship, held at Washington last September; promotes interest in international affairs by such activities as sending representatives to meetings of the International Council of Nurses, distributing information about the United Nations and World Health Organization, and focussing many of its meetings on world topics; has petitioned the ICN to form an international student unit; supports the polio vaccination program and other health drives; has voted to establish a scholarship fund for nursing students. HSNA can be proud of such a live-wire parent organization.

The purposes of the NSNA are:

1. To aid in the development and growth of the individual student by fostering good citizenship.

2. To stimulate interest and understanding among student nurses of the programs and activities of the national graduate nursing organizations.

3. To serve as a channel of communication and to provide a closer bond and a more unified spirit among student nurses through group and national activities and through cooperation with other student nurses' associations throughout the world.

The purposes of HSNA parallel those of NSNA (which is the case with every state constituent). For example our HSNA exists for these purposes:

1. To aid in the development of student nurses as democratic citizens by broadening their horizons as individuals and as members of a group.

2. To promote professional and social unity among the student nurses of the Hawaii Student Nurses' Association.

3. To stimulate an understanding of and an interest in the program of the graduate professional nursing organizations.

4. To serve as a channel of communication between the student nurses' organizations and various units of graduate professional nurses' organizations.

5. To participate as an active constituent of the National Student Nurses' Association through duly elected representatives.

NSNA and HSNA are self-supporting. National Student Nurses' Association derives its income from individual dues of 50¢ per member. Hawaii Student Nurses' Association collects $1.00 in dues and sends half to NSNA. In addition to income from dues, HSNA may elect to conduct a fund raising project each year for the scholarship program and to send a delegate to the NSNA Annual Convention which is always held in conjunction with either the National League for Nursing or the American Nurses' Association Conventions which are held biennially on alternate years.

There has been a close tie between HSNA and the Hawaii Nurses' Association and the Hawaii League for Nursing. This tie was made official in 1960 when the Boards of these graduate nurses' associations voted to be the official sponsors of Hawaii Student Nurses' Association.

Since 1959 HSNA has held bi-monthly meetings for all members. These general membership meetings keep students informed about HSNA activities and there is usually an interesting program which is an expression of HSNA purposes. The Mabel Smyth Building Management Board granted courtesy privileges to HSNA in the use of the Mabel Smyth Building auditorium which makes possible the assembly of our whole membership of approximately 300.

The Executive Council is the governing group of HSNA and the Council meets every month to conduct organization business. The seven (7) standing committees carry on the certain housekeeping functions of HSNA, and make a very important contribution to association affairs. These committees are: Arrangements and Hospitality, Constitution and Bylaws, Finance, Nominations, Program, Public Relations and Publicity, and Scholarship. The President may appoint other committees as the need arises.

Membership is open to every student enrolled in a state accredited school preparing for professional nursing. HSNA is not a federation of the student organizations of schools of nursing. Membership is only held by individual nursing students.

Being active members of HSNA means that student nurses are better prepared in organizational work when they graduate. They have firsthand experiences in understanding the program of both graduate professional nurses' organizations —the Hawaii Nurses' Association and the Hawaii League for Nursing. Both sponsors invite HSNA representatives to meetings of their Boards, committees and to membership meetings. A student who really participates in HSNA becomes well prepared for her role as a graduate professional person in the community.

Super Stamp Flight

If there is one thing a nurse must know, it is how to improvise. But to improvise for money? It *can* be done—here's the story.

It was expected that the Hawaii Nurses Association would be represented at the ANA Convention by its president. This convention was held in Miami Beach, Florida, in May. The distance was long and the air fare great. The budget just did not

contain the needed $506.60, so some improvisation was necessary. We found it in the form of savings stamps.

The Aloha Stamp Company, Ltd., was interested in helping us through their deferred payment plan. A contract to pay 206 books of Super Savings Stamps within one year was signed and the air ticket (tourist) was purchased early in April.

The response to our letters to HNA members asking for stamps was immediate and generous and the full amount (206 books) was paid up by May 11.

The HNA was ably represented by our President, Sister Maureen, who was elected as a director to the Board of ANA.

The flight by stamps caused much favorable interest at the convention and the Florida State Nurses Association even offered to help with their green stamps.

So we thank all of those who helped us to improvise Aloha Stamps for money, thus supplying the wings for Sister Maureen's trip to ANA Convention.

MARY M. WALSH

ANA Convention Summary

ELECTION RESULTS—ANA

President: Mathilda Scheuer
1st Vice President: Mary C. Walker
2nd Vice President: Margaret B. Dolan
3rd Vice President: Georgia B. Nyland
Secretary: Julie M. Carnahan
Treasurer: Louise Alcott
Board of Directors: Agnes E. M. Anderson, Alice M. Klump, Sister Maureen, Elizabeth K. Porter

In response to 1958 House of Delegates mandate to explore the possibility of ONE organization, ANA now has established a Committee to explore ANA functions. The National League for Nursing has also indicated that it will have a similar Committee and each will share with the other what is crystallized in these committee meetings *before* publishing any statements at all. To my mind this is progress in a situation that could have really been explosive if not handled correctly. It was my pleasure to have supper one evening—accidentally—with Lucille Petry Leone—NLN President. (The accident was that I was alone at the table and she asked if she might join me.)

The resolution on discrimination which was read at our Board meeting was replaced by the final resolution to exhort, encourage, and assist the one State (Georgia) still excluding Negroes from membership to use every means to expedite the integration so that by 1962 all states will be fulfilling ANA code. This, too, was really an explosive situation in view of the crisis in Miami itself during the convention as indicated by national newspaper coverage—aside from the nurse group. Elizabeth Moran of Michigan—chairman of INSA—made the motion for encouragement rather than a severance of the State's membership in ANA. Since Georgia has been making great strides to conform, it was felt that an injustice might be done to them by cutting them off at this time when they were trying to move in a civic situation which presented obstacles that Northern States and others might not appreciate because they had no like problems. I felt that this whole issue was handled with grace and prudence and with a cognizance that all eyes were on ANA that day in the light of the civil rights battle. While I am vehemently opposed to all discrimination, it seemed that one injustice could not be corrected by another injustice and harm might have been done to every one concerned by rash action of our organization in a nation-wide situation of concern.

INSA section name has been changed to INA to clarify status for membership.

ANA is concerned about the "wooing" away of nurses in organization outside of ANA—such as OR nurses, Occupational Health, Psychiatric and Maternal and Child Health. Conference groups within ANA seem to be the answer to meet an obvious need. My own reaction to this trend is most optimistic. I think it indicates nurses' basic and fundamental desire to learn more about how to give the best nursing care to patients. Some states recognize this and are now planning clinical conferences for such groups. California just voted to have biennial conventions and in the alternate years to have clinical conferences for nurses. In this age of specializing, nurses need to keep abreast of the times and ANA—I think—should do all it can to sponsor growth in professional competence.

Professional Practice Committees were discussed as vital to good nursing and I was a little embarrassed that our State Committee was listed as having had *no* meetings!

Michigan proposed a resolution which was accepted—to the effect that ANA should be directed to allocate funds and conduct a Public Relations program to educate the public on the contributions being made by nurses. Their own personal need for recognition—economic—security-wise—would then be accepted and furthered in the mind of the public. Personally I think this is most desirable—it will, as it were, switch the mind of the public to the positive contribution of nurses and indirectly further the economic security program without emphasizing the *image* now in the public's mind of associating nurses with the mighty dollar sign! I'm all for economic security but I think womanly strategy should devise means by which

the picture conjured up in the public eye emphasizes the *professional* side of nursing. It will be interesting to watch this development.

ANA Professional Code revisions were accepted. There is a copy in HNA office which incorporates the changes.

The Committee on Long Range Goals carried the approval of the House of Delegates with Georgia protesting. The major point made was that:

> Within 20-30 years all professional nurse education should be given in a degree-granting institution.

To me the implication has been obvious and the handwriting is on the wall. The 3-year program may continue as may the two-year (now in degree-granting institutions) but their graduates will probably be thought of as technicians.

SISTER MAUREEN

Economic Security Workshop

Over 120 people attended the two-day Economic Security Workshop held July 7 to 9, 1960. At the Saturday night dinner at the Princess Kaiulani Hotel Dr. Edwin C. Pendleton, Associate Professor of Business Economics at the University of Hawaii, captivated the group with his talk on "Collective Bargaining--A Rational Mode of Problem Solving." Dolores Le Hoty, ANA Assistant Executive Secretary in charge of the Economic Security Program of the ANA, spoke Friday on "Economic Security—A Right and a Privilege."

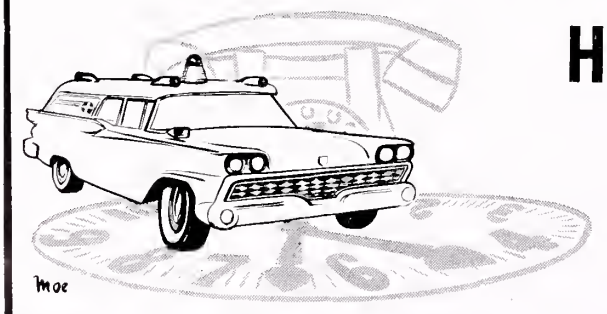
If you were unfortunate enough to have missed this stimulating experience, be certain to save October 20, 21, and 22 for the HNA Convention on Maui, at which time recommendations based on the findings brought out in the Economic Security Workshop will be presented and you will decide how they will affect our total program.

Plan to attend

29th ANNUAL MEETING, HNA

Maui

OCTOBER 20, 21, & 22
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References: (1) Antos, R. J.: Southwestern Med. *40*:695-697 (Nov.) 1959. (2) Tullis, I. F.: Initial Experience with a Simple Weight Control Formula, to be published. (3) Roberts, H. J.: Effective Long-Term Weight Reduction—A Therapeutic Breakthrough, to be published.



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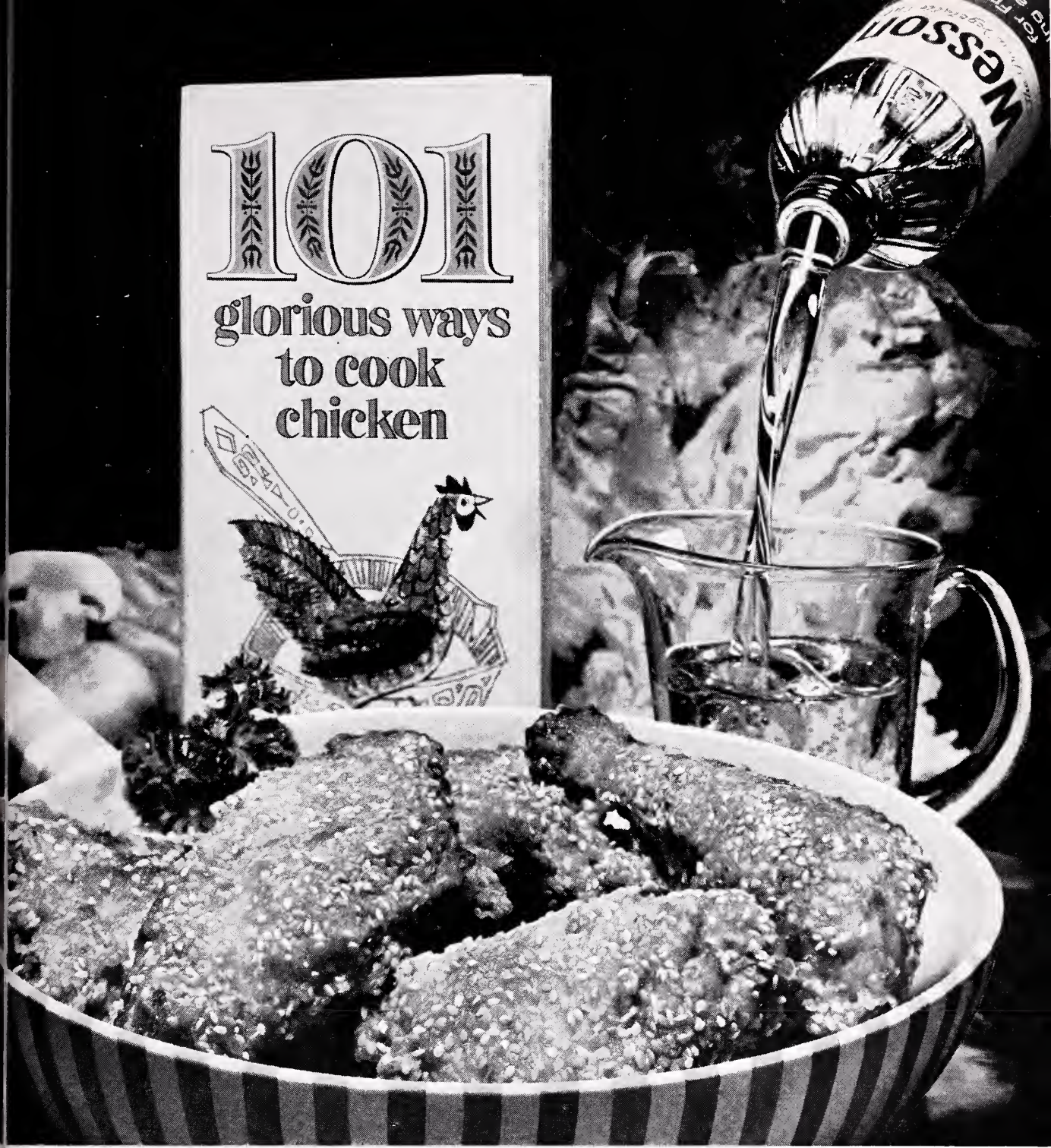


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BOOK REVIEWS

(Continued from page 663)

and useful essays on such subjects as anesthesia, vermifuges, tranquillizers, hormones, and so on.

Drugs of Choice 1960-1961

Edited by Walter Modell, 913 pp., $13.50, C. V. Mosby, 1960.

Medical practice from the pharmaceutical standpoint. Full of information.

★Current Therapy—1960

By Howard F. Conn, M.D., 808 pp., $12.00, W. B. Saunders, 1960.

No review is needed for this well-known, annually revised, reliable and intensely practical volume on treatment. Each article is signed by the specialist who wrote it.

Radiologic Records

By Sr. Christina Spirko, 304 pp., $8.25, Charles C. Thomas, 1960.

For a young radiologist and maybe a few older ones. Explicit and lucid and beautifully printed.

The Surgical Clinics of North America, Vol. 40, No. 1

Ormand C. Julian, M.D., Guest Editor, pp. 1-256, W. B. Saunders Company, February, 1960.

A symposium on improved surgical techniques and

(Continued on page 700)



Lila G. Ponce, R.N.
Director

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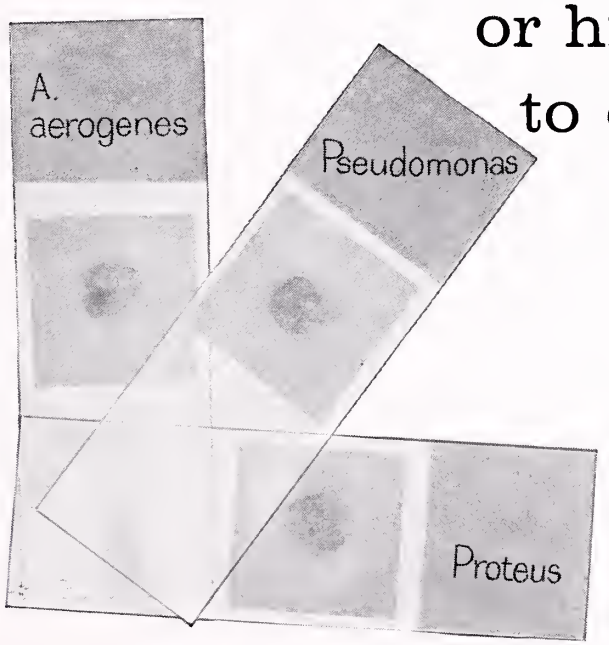
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1. Finland, M.; Hirsch, H. A., and Kunin, C. M.: Read at Seventh Annual Antibiotics Symposium, Washington, D. C., November 5, 1959. 2. Hirsch, H. A.; Kunin, C. M., and Finland, M.: **München. med. Wchnschr.** To be published. 3. Roberts, M. S.; Seneca, H., and Lattimer, J. K.: Read at Seventh Annual Antibiotics Symposium, Washington, D. C., November 5, 1959. 4. Vineyard, J. P.; Hogan, J., and Sanford, J. P.: **Ibid.**

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

ETHEL NISHIBATA, *Editor* MUN FOOK SHINN, *Associate Editor*

President's Message

Let's start with you, the members of the Hawaii Society of Medical Technologists. Today, this Society is a professional organization for medical technologists and others in related fields. Slated to be the busiest group in any state, HSMT is expanding to a degree that it becomes an important part of the American Society of Medical Technologists.

For the coming year there will be seminars, informal dinner meetings, and lectures by leading medical men. There will be a post convention of the American Society of Medical Technologists in June, 1961. At that time look forward to good fellowship and learning and even old fashioned Hawaiian entertainment with twentieth century touches.

Let us make our twelfth year as fruitful as the past eleven, as streamlined as a missile launching, for never before has there been such a stimulating opportunity for advancement. Let us strive for greater achievements with the support of all old members and any new members, get-up-and go individuals who volunteer with impressive ease, and with the Executive Board of two men and five women to start the count down. Act now if you want to find out the latest in medical technology, to improve yourself technically, to be in on things, and to contribute fresh, new ideas or even criticism, volunteer your very special talents to HSMT.

LORENE LEONG

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The Role of the Laboratory in the Detection and Control of Staphylococcal Epidemic in a Hospital

RALPH H. TANIMOTO, M.S.
Assist. Chief, Bureau of Laboratories
State of Hawaii, Department of Health

According to a statement found in the article Medical Year in Review, which appeared in the January 14, 1959, issue of *Medical News,* "the most pressing medical problem of 1958 proved not to be—as might be expected—an exotic Asian strain of mutant virus, but resistant strains of one of the commonest and best known of pathogenic bacteria: Staphylococcus aureus."

Due to the alarming increase in the number of infections caused by antibiotic resistant staphylococci together with such tragic proofs as the explosive outbreaks in Houston and Dallas, Texas which took the lives of 25 babies within a short period of time, the interest and awareness of the importance of this organism has gained national and international prominence.

Hospital infections caused by "epidemic" strains, particularly phage type 80/81, to which is accorded the pseudonym "hospital" strain, have created a serious problem not only in this country but also in England, Australia, and Canada. Hawaii, although gifted in many respects, is no exception when it comes to possessing its share of antibiotic resistant, type 80/81, Staphylococcus aureus. Table I shows the distribution of this type as found in specimens received from the various submitting agencies.

Thus, of the total of 2,012 coagulase positive Staph. aureus cultures received by the Department of Health laboratories in 1958 for bacteriophage typing, 610 or 30.3% were type 80/81. In 1959 there were 405 out of 1,913 or 21.2%. The percentage distribution of type 80/81 among six hospitals submitting the greatest numbers of specimens ranged from 21.4% to 57.6% of Staph. aureus cultures in 1958 and 18.6% to 60.0% in 1959.

Of particular concern to public health officials is the high incidence of 80/81 among specimens submitted by physicians and clinics. These cultures have been isolated from presumably non-hospitalized individuals who may have acquired the infection in their homes, in the community or perhaps in a hospital. Although data are not available, it requires no effort to visualize these individuals, whose movements are neither confined nor impeded to any extent, disseminating the organism in their community. Such high incidences of 80/81 among the specimens submitted by clinics and physicians poses a question, "Is the hospital strain now a community strain?"

The striking characteristic of 80/81 is its resistance to antibiotics (Table II). Of the total of 1,015 cultures tested for antibiotic sensitivity during 1958 and 1959, 84.2% were found to be resistant to aureomycin, 69.0% to penicillin, 86.7% to terramycin, 86.5% to tetracycline, 90.2% to dihydrostreptomycin, 10.0% to erythromycin and 14.5% to oleandomycin, whereas only 0.6% were resistant to bacitracin, 1.0% to neomycin, 6.3% to carbomycin and 1.8% to novobiocin. Compared with this, only 0.4 to 11.2 per cent of all other phage types were resistant to these antibiotics.

Such characteristics as virulence, communicability and antibiotic resistance pose special problems in the control of staphylococcal infections in a hospital. The detection and control of staphylococcal epidemics in hospitals will require well organized, cooperative and concerted efforts on the part of the hospital staff, the hospital laboratories and the public health laboratories. The initial isolation and identification of coagulase positive staphylococcus strains should be carried out by the hospital laboratories and the subsequent bacteriophage typing for epidemiological investigations performed by the state public health laboratories or the regional staphylococcus phage typing centers.

The National Conference on Hospital Acquired Staphylococcal Disease which was held in Atlanta, Georgia from September 15 to 17, 1958, recommended that hospitals throughout the country, even the smallest hospitals, include in their laboratory programs the isolation of staphylococci and the determination of coagulase activities and antibiotic sensitivity patterns. In this respect, the hospital laboratories can contribute invaluable serv-

TABLE I
Distribution of Staph. aureus Type 80/81 by Source Submitting Specimens

YEAR	TOTAL STAPH. AUREUS CULTURE		CLINICS AND PHYSICIANS		CIVILIAN HOSPITALS AND INSTITUTIONS		U.S. GOVERNMENT AGENCIES		OTHER ISLANDS	
	No.	%	No.	%	No.	%	No.	%	No.	%
1958	610/2012	30.3	78/156	50.0	389/1174	33.1	106/519	20.4	37/163	22.7
1959	405/1913	21.2	70/274	25.6	293/1218	24.1	18/118	15.3	24/303	7.9

Numerator—number of 80/81 cultures.
Denominator—number of Staph aureus cultures.

TABLE II

Antibotic Resistance of Staph. aureus Type 80/81 and All Other Phage Types

Antibiotic	Per cent of cultures resistant					
	Type 80/81			All other phage types		
	1958	1959	both years	1958	1959	both years
Aureomycin, 5 mcg	82.8	86.3	84.2	11.0	8.9	10.0
Penicillin, 2 units	75.8	58.4	69.0	9.0	4.6	6.9
Chloromycetin, 5 mcg	2.0	4.2	3.0	2.2	1.3	1.8
Terramycin, 5 mcg	86.5	86.7	86.7	11.4	9.5	10.5
Erythromycin, 2 mcg	6.0	15.8	10.0	0.5	4.0	2.2
Tetracycline, 5 mcg	86.4	86.5	86.5	11.5	9.6	10.6
Dihydrostrep., 2 mcg	91.1	88.7	90.2	11.8	10.5	11.2
Oleandomycin, 2 mcg	....	14.5	14.5	....	1.3	1.3
Bacitracin, 2 units	1.5	0.0	0.6	2.1	0.2	0.8
Neomycin, 5 mcg	1.1	0.9	1.0	1.0	0.5	0.7
Carbomycin, 2 mcg	....	6.3	6.3	....	1.2	1.2
Novobiocin, 5 mcg	3.3	0.0	1.8	0.6	0.1	0.4

ices in the diagnosis and therapy of staphylococcal disease as well as in the detection and control of hospital acquired staphylococcus infections by instituting such a program.

It is essential that periodic "preventive surveys" be conducted to determine the extent of staphylococcus entrenchment in the hospital and to have a record system which is sensitive enough to detect sudden changes in frequencies or trends in this type of infection.

The provision of adequate laboratory services will require well-trained bacteriologists and laboratory technicians capable of carrying on techniques of a very exacting nature, not to mention the high cost of operation of such a continuing survey. However, with united efforts on the part of hospital laboratories and the public health laboratories, this challenge could and is being met.

The precise methods of collection of specimens and procedures for the isolation and detection of Staphylococcus aureus are clearly outlined in the "Recommended Procedures for Laboratory Investigation of Hospital-Acquired Staphylococcal Disease," Appendix A of Proceedings of the National Conference on Hospital-Acquired Staphylococcal Disease, U.S.P.H.S.

Bacteriophage typing of staphylococci lends no advantage nor do the findings bear any significance in the diagnosis and therapy of the disease. It merely provides a more precise identification of individual strains than is possible by any other laboratory method. It is the only reliable and practical epidemiologic tool employed today in tracing the source and spread of staphylococcal infections. It has been used successfully in detecting carriers, enrironmental sources, foods incriminated in staphylococcus food poisoning outbreaks, etc. It has repeatedly demonstrated the relationship between the infected individual or material and the source of the infection. Simultaneously, valuable information is obtained on the mode of infection.

It is inadvisable for any laboratory, particularly the hospital laboratory for reasons already stated, to attempt phage typing even if there are adequate personnel, facilities and funds to support such a program. Phage typing should be limited specifically to epidemiologic or research studies. For uniform and comparable results these epidemiological studies should all be done by the designated typing center.

Whenever the need for phage typing arises or is contemplated, the hospital or institution should seek assistance of the Bureau of Laboratories of the State Department of Health which serves as the Regional Staphylococcal Phage Typing Center for the State of Hawaii and the Trust Territory.

Summary

1. The initial isolation and identification of Staphylococcus aureus should be performed in the hospital laboratory.

2. Only coagulase positive cultures should be submitted for bacteriophage typing and only after pre-arrangement with the typing center.

3. The cultures should be accompanied by pertinent information, including not only the antibiotic sensitivity pattern, but also a brief history of the patient or other source of the isolation.

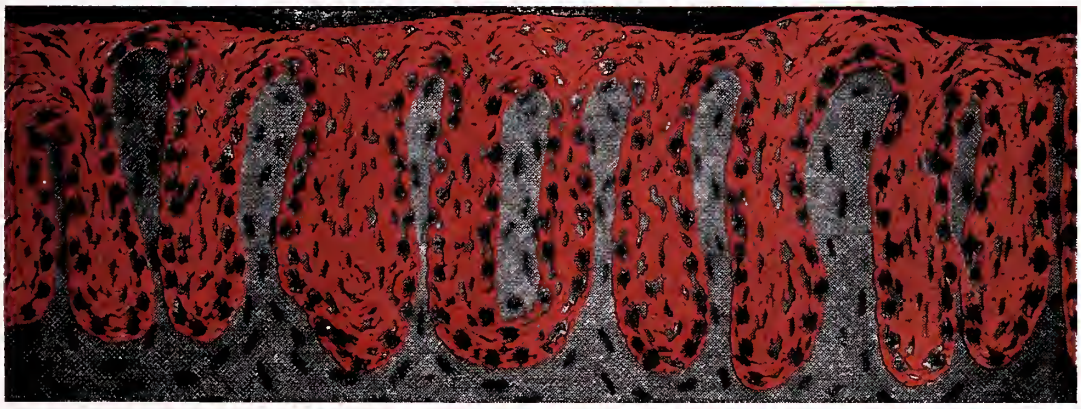
4. The cultures should be kept in a refrigerator until a suitable number of related isolations have been accumulated.

5. The successful detection and control of staphylococcal epidemics in a hospital requires the unified effort of the hospital staff, the hospital laboratory and the regional staphylococcal bacteriophage typing laboratory.

Highlights of a talk given to members of the Hawaii Society of Medical Technologists on Feb. 25, 1959. Due to the delay in publication, the author has reviewed his presentation and has included 1959 figures.

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BOOK REVIEWS

(Continued from page 694)

therapeutic advances being applied to major vascular problems.

Pediatric Clinics of North America, Vol. 7, No. 1

Lyman T. Meiks, M.D., and Morris Green, M.D., Consulting Editors, pp. 1-232, W. B. Saunders Company, February, 1960.

A symposium on adolescence focused on the ordinary difficulties that may be encountered by the ordinary physician.

Current Approaches to Psychoanalysis

By Paul H. Hoch, M.D., and Joseph Zuzin, Ph.D., 207 pp., $6.50, Grune & Stratton, 1960.

For psychiatrists only—and not all of them.

Significant Trends in Medical Research

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., 356 pp., $9.50, Little & Brown, 1960.

For researchers, a must. For others, a may. The essays are mostly pretty deep, thought instructive.

Surgical Clinics of North America, Vol. 40, No. 2

Edited by William L. White, M.D., 573 pp., W. B. Saunders Co., 1960.

Pittsburgh on hand surgery. Very well done.

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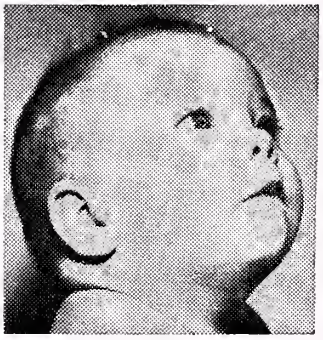
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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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REFERENCES: 1. Gifford, R. W., Jr., *In* Hypertension, ed. by J. H. Moyer, Saunders, Philadelphia, 1959, p. 561. **2.** Moyer, J. H.: *Ibid.* p. 299. **3.** Brodie, B. B.: *In* Hypertension, Vol. VII, Proceedings Council for High Blood Pressure Research, Am. Heart Assn., ed. by F. R. Skelton, 1959, p. 82. **4.** Wilkins, R. W.: Ann. Int. Med. 50:1, 1959. **5.** Freis, E. D.: *In* Hypertension, ed. by Moyer, *op. cit.*, p. 123. **6.** Ford, R. V., and Nickell, J.: Ant. Med. & Clin. Ther. 6:461, 1959. **7.** Fuchs, M., and Mallin, S. R.: Int. Red. Med. 172:438, 1959.

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(Continued from page 665)

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b. The expenditure of National Foundation local chapter funds for financial assistance for medical care and for professional education should have the approval of the Medical Advisory Committee. Determination of the extent and degree of eligibility for financial assistance for medical care should be made by the Medical Advisory Committee. In economically borderline cases, the Medical Advisory Committee should determine to what extent the local chapter may assist in the payment of paramedical services.

c. The National Foundation should make no payment for physicians' services, except as outlined in its memorandum dated August 1959. (See Addendum A.) Fees for physicians' services rendered to patients will be arranged privately between the patient and physician. The necessary steps should be taken to clarify this point with chapter members, the general public and the patients concerned.

d. Each Chapter which extends aid to patients receiving professional medical or surgical service in a specific medical community should conform to the policies of the Medical Advisory Committee of the component medical society in the community in which the treatment is rendered.

e. Doctors who agree to serve on such Medical Advisory Committees should be aware of the responsibilities attendant upon such positions and offer constructive leadership in this respect.

In a series of actions the House of Delegates

Advocated certification rather than licensure of paramedical groups.

Instructed the Trustees to implement a study of the requirements of hospitals in regard to content and preparation of records, to eliminate inefficiency and duplication of effort.

Urged that physicians take every opportunity to improve medical liaison with the nursing profession, especially by serving on Advisory Committees when invited to do so.

Viewed "with grave concern the indiscriminate use of contact lenses," and reiterated that they should be fitted by physicians.

Referred to the Board of Trustees a resolution to separate the Sections of gastroenterology and proctology.

Shortened to 60 days (plus 30 days optional leeway) the period during which appeals may be made to the Judicial Council from decisions made by a constituent association.

Decided to continue charging medical schools, libraries and hospitals for A.M.A. scientific publications.

Reaffirmed its opposition to the inclusion of non-service-connected disabilities under the veterans' medical care program.

Hoped that economies might make a raise in dues unnecessary.

Scheduled annual meetings for Atlantic City in 1963, San Francisco in 1964, and New York City in 1965.

Requested the Council on Drugs to submit an objective appraisal of the American pharmaceutical industry to the House in June, 1961.

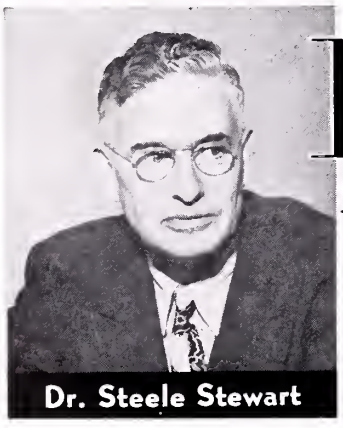
Affirmed the need for special training for physicians wishing to qualify to give physical examinations for Class III pilots' licenses.

Reiterated support of the Blue Shield concept, and in doing so specifically deleted the phrase "in the low and middle income ranges" in a section defining the people to be helped.

Encouraged physicians to take a more active part in public affairs in general and politics in particular.

Your Delegate served on the Reference Committee on Amendments to the Constitution and Bylaws at this session, and your Alternate Delegate, President and Executive Secretary represented the Association at other hearings.

HARRY L. ARNOLD, JR., M.D.
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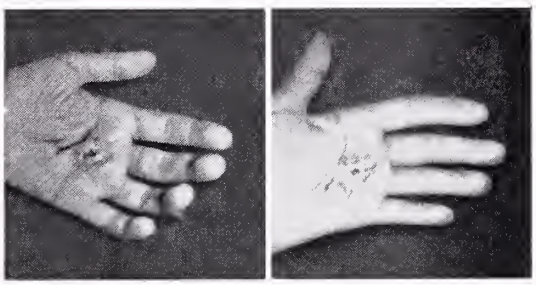
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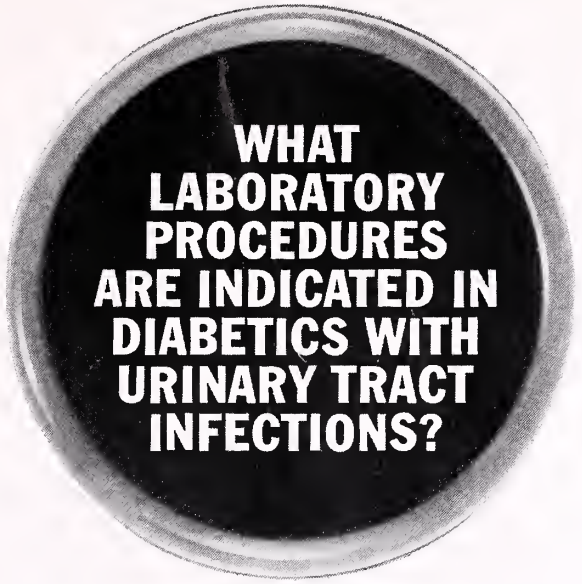
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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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